



2003

Psychiatric Evidence on Trial

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Joanmarie Ilaria Davoli, *Psychiatric Evidence on Trial*, 56 SMU L. Rev. 2191 (2003)
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PSYCHIATRIC EVIDENCE ON TRIAL

Joanmarie Ilaria Davoli*

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INTRODUCTION

“WHAT do I have to do—have him kill someone before something will be done?”¹ asked the mother of the schizophrenic, delusional young Mr. Head,² who was respond-

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1. Psychological Report at 7, *Commonwealth v. Head*, No. 95018 (Fairfax, Va. 1999) (prepared by William J. Stejskal, Ph.D.) (statement of Zona Head).

2. This author defended Mr. Head on the charge of first degree murder of his mother, Zona Head, in Criminal Case No. 95018, Fairfax County Courthouse, 4410 Chain Bridge Road, Fairfax, Virginia 20030.

ing to command hallucinations that demanded he kill both himself and his parents. Nine days later, he sawed at his throat with a knife, cutting all the way through his trachea. Throughout the six weeks after surviving emergency surgery for his transected trachea, Mr. Head continued to refuse psychiatric treatment. He then drove his mother's car into the house, pulled out a baseball bat, and beat his mother to death.³ Although the life-saving surgical procedure to repair his severed throat had been forced upon him without waiting for his consent, psychiatric treatment never was. Three days before he killed his mother, Mr. Head went back to the same hospital, still suffering delusions, and reported feeling suicidal and homicidal.⁴ A few hours later, he left the hospital against medical advice prior to receiving any psychiatric treatment. He fit the scientific profile of an individual poised to become extremely violent,⁵ but no one attempted to hold him against his will to keep him from acting on his command hallucinations, and no one requested court-ordered involuntary psychiatric treatment.⁶ His mother was right. Nothing was done until he killed someone—her.⁷

Yet compare the failure to recognize the future dangerousness of Mr. Head with the confident prediction of the future expressed in Randall Dall Adams' case below. The volatile and delusional nature of Mr. Head's illness was ignored, even while he expressed suicidal and homicidal thoughts. In sharp contrast, psychiatrist Dr. Grigson's prediction that Mr. Adams would kill in the future was sworn to be absolute.⁸

Dr. Grigson, diagnosed Mr. Adams "as being a (sic) sociopathic personality disorder. On the scale of sociopathy, . . . I would place Mr. Adams at the very extreme, worse or severe end of the scale. You can't get beyond that . . . there is nothing known in the world today that is going to change this man, we don't have anything."⁹ Dr. Grigson confidently proclaimed that Mr. Adams "would continue to be a threat to society," after asserting that Mr. Adams would have no regard for the lives or property

3. Peter Pae, *Man Found Insane in Mother's Killing*, WASH. POST, Oct. 26, 1999, at B7.

4. "Three days after Alfred L. Head walked out of the psychiatric unit at Inova Fairfax Hospital in July 1998, he beat his mother to death with a baseball bat in their Reston home. Less than two months earlier, he'd been in the same unit after slashing his throat to the windpipe and leaping headfirst off a balcony." Tom Jackman, *Doctor, Nurses Acquitted in Insanity Case; Va. Man Who Beat Mother to Death Shouldn't Have Left Hospital, Father Says*, WASH. POST, May 11, 2001, at B2.

5. See discussion *infra* Part II.B.

6. "[Some] compared the tragedy to the shootings at the U.S. Capitol . . . [in that] the suspect . . . was not kept at a mental hospital despite a history of mental problems . . . [one neighbor] said the family had told him that the son often resisted efforts to keep him in treatment plans." Wendy Melillo & Erica Beshears, *Man Charged in Mother's Death; Friends Say Woman Had Struggled With Son's Mental Condition*, WASH. POST, Aug. 1, 1998, at B3.

7. Pae, *supra* note 3, at B7.

8. MICHAEL L. RADELET ET. AL., IN SPITE OF INNOCENCE: ERRONEOUS CONVICTIONS IN CAPITAL CASES 66 (1992).

9. *A Danger to Society: Fooling the Jury with Phony Experts* (quoting Tr. at 1407, Adams v. State (CCA No. 60,037)), in *A State of Denial: Texas Justice and the Death Penalty*, available at <http://www.texasdefender.org/study/chapter3.html>.

of others, wherever they might be: "It wouldn't matter where it was [or whose life], you or a guard or a janitor or whoever it might be."¹⁰ On May 3, 1977, Randall Dale Adams was sentenced to death for a crime he did not commit.

Seven days before Mr. Adams' scheduled execution in 1979, the U.S. Supreme Court granted a stay of execution, and ultimately reversed the death sentence but not the conviction.¹¹ "Finally, on March 21, 1989—exactly twelve years and three months after being taken into custody—Randall Dale Adams was released."¹² He had been completely exonerated when the star prosecution witness, himself sentenced to death for another murder, admitted that he lied, and additional evidence proved that Mr. Adams was never involved in the murder. Thus, in spite of the psychiatrist's dire vision of Mr. Adams' future behavior, there have been no acts of violence or arrests for any crime. Neither while incarcerated nor since his release in 1989 has Mr. Adams been anything other than non-violent.¹³

These two cases demonstrate a strange paradox in psychiatric testimony. In cases where psychiatry can make fairly accurate predictions—such as young, schizophrenic Mr. Head's propensity to become violent—either no court action is taken, or the psychiatric prediction is minimized. In capital murder cases where psychiatry has no greater ability to accurately predict the future than does common sense, psychiatric testimony is heavily relied upon.¹⁴ The distinction between these two cases is that Mr. Head was suffering from a mental illness that produced delusions, and under such conditions psychiatry has developed fairly reliable criteria for predicting violence in the near future.¹⁵ Mr. Adams, however, was not diagnosed with a mental illness that results in psychosis.¹⁶ Rather, Dr. Grigson was using the lay term, sociopath,¹⁷ to refer to anti-social

10. *Id.* (alteration in original) (quoting Tr. at 1410, *Adams v. State* (CCA No. 60,037)).

11. *Adams v. Texas*, 448 U.S. 38 (1980); RADELET ET AL., *supra* note 8, at 67, 72.

12. RADELET ET AL., *supra* note 8, at 72.

13. *A Danger to Society*, *supra* note 9.

14. DAVID L. FAIGMAN ET AL., *SCIENCE IN THE LAW: SOCIAL AND BEHAVIORAL SCIENCE ISSUES* (2002).

[E]xpert testimony predicting violence has been, and remains, an extraordinarily controverted use of science in the trial process. In fact, courts regularly remark that predicting future behavior is inherently difficult and most research indicates that psychiatrists and psychologists do not do it well. This area of the law thus presents a paradox in which judges seemingly take the most lenient approach toward scientific evidence involving some of the most controversial science to enter the courtroom.

Id.

15. See discussion *infra* Part II.B.

16. "The narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition would also include prominent hallucinations that the individual realizes are hallucinatory experiences." AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL* 273 (4th ed. 1994) [hereinafter *DSM-IV*].

17. Antisocial personality disorder "has also been referred to as psychopathy, sociopathy, or dyssocial personality disorder." *Id.* at 645.

personality disorder,¹⁸ a diagnosis that does not include delusions or hallucinations.

At the time of Dr. Grigson's testimony and continuing on to today, no methodology for accurately predicting future violence based on the diagnosis of anti-social personality disorder exists.¹⁹ Thus, Dr. Grigson's testimony would have failed the federal test for admissibility of scientific evidence. This standard, articulated by the Supreme Court in *Daubert v. Merrill Dow Pharmaceuticals, Inc.*,²⁰ applies only to federal cases. Nonetheless, it is a useful model for the discussion of the admissibility of scientific evidence in general. An examination of psychiatric testimony within the *Daubert* admissibility framework reveals the flaws of current usage of such testimony.²¹

Part I of this article explains that predictions of future violence are routinely made by psychiatrists in both capital murder trials and civil commitment hearings and describes the difficulties inherent in both usages. Part II of this article examines the reliability of both psychiatric diagnoses as well as the ability of psychiatrists to predict violence. Part III concludes with an explanation of why such testimony should only be admissible when it meets the relevancy and reliability test expressed in

18. The American Psychiatric Association provides the criteria for anti-social personality disorder:

Diagnostic criteria for 301.7 Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

- (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- (3) impulsivity or failure to plan ahead
- (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
- (5) reckless disregard for safety of self or others
- (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of Conduct Disorder with onset before age 15 years. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

Id. at 650.

19. *Barefoot v. Estelle*, 463 U.S. 880, 920 (1983) (Blackmun, J., dissenting) ("The American Psychiatric Association (APA) . . . informs us that 'the unreliability of psychiatric predictions of long-term future dangerousness is by now an established fact within the profession.' . . . [at] best two out of three predictions of long-term future violence made by psychiatrists are wrong."); see also Thomas A. Widiger & Timothy J. Trull, *Personality Disorders and Violence*, in *VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT* 203-26 (John Monahan & Henry Steadman eds., 1994) ("Surprisingly, systematic research on violent, aggressive tendencies among the mentally disordered has rarely considered disorders of personality [which includes anti-social personality disorder].").

20. 509 U.S. 579 (1993); see discussion of the *Daubert* holding *infra* Part III.A.

21. See discussion *infra* Part III.A.

Daubert.²²

I. PREDICTIONS OF FUTURE DANGEROUSNESS

Predictions of whether or not an individual will pose a danger in the future arise in various settings. Criteria for release of a criminal suspect on bond typically include whether the individual poses a risk of flight or is dangerous to the community.²³ Decisions regarding sentencing, such as whether to grant probation or to sentence a defendant to a “halfway” house or other community-based punishment, always include an inquiry into the defendant’s potential for future dangerousness.²⁴ Parole boards often consider not only the amount of time the prisoner has served, but also whether the defendant is likely to re-offend.²⁵

One example of a scenario in which a court must predict future behavior occurs at a bond hearing after a defendant has been arrested. During a bond hearing, the court is presented with a short summary of the facts of the crime, the details of any prior criminal record, the defendant’s employment status, residence and other ties to the community, and argument by counsel.²⁶ Typically, there is no testimony given by witnesses. Instead, the evidence is proffered by the prosecutor and defense attorney. After proffer and argument, the court independently determines whether and under what circumstances to release the defendant pending trial. No expert evidence is presented to assist the court in predicting whether a defendant is likely to become a danger to the community once released. The court merely applies common sense to the facts. Typically, a higher bond is set if the court finds any of the following evidence to exist: prior history of violent crime; current charge is a violent crime; prior failures to appear for court proceedings; lengthy criminal record, even if non-violent; no fixed address; no employment; no family or friends living in the area.²⁷ The court does not defer to a psychiatric expert to explain the significance of those facts, but relies upon its own wisdom.

In a small minority of hearings, psychiatric testimony is offered and relied upon, typically as evidence of whether the individual will pose a threat in the future. The two primary types of court proceedings in which psychiatrists and psychologists routinely testify are the penalty phase of capital murder trials and civil commitment hearings. While experts testify in both types of cases, the weight given in each varies widely.

22. *Daubert*, 509 U.S. at 579.

23. For example, the Bail Reform Act of 1984 states that the court should consider whether releasing the defendant will “endanger the safety of any other person or the community.” 18 U.S.C. § 3142(b) (2003); *see also id.* § 3142(g)(4).

24. 18 U.S.C. § 3553(a)(2)(C).

25. 18 U.S.C. § 3552(2)(1)(A) (requiring courts to consider the factors enumerated under 18 U.S.C. § 3553(a) in considering reduction of prison sentence).

26. 18 U.S.C. § 3142.

27. 18 U.S.C. § 3142(g)(1)-(4).

A. CAPITAL MURDER

Capital murder cases are tried in two phases. The first phase is the guilt or innocence portion, where the jury decides whether the defendant killed the victim and whether the elements of capital murder are satisfied. The second phase of the trial is the penalty phase, in which the jury decides whether to sentence the defendant to life imprisonment or the death penalty. During the penalty phase, the prosecution is required to prove aggravating circumstances: evidence that demonstrates that this defendant is so evil or this murder is so repugnant that the death penalty is justified.²⁸ The defense has the opportunity to introduce "mitigating" evidence.²⁹ Such testimony can include the defendant's youth,³⁰ good behavior while incarcerated,³¹ childhood abuse,³² and any other evidence that demonstrates why the defendant deserves a sentence less than death.³³

In several states one issue the jury may consider in choosing between a life or death sentence is whether the defendant will commit future acts of violence.³⁴ Typically, the prosecution presents the testimony of a psy-

28. See, e.g., *Gregg v. Georgia*, 428 U.S. 153 (1976) (requiring the jury to consider the nature of the crime and the specific characteristics of the defendant does not violate the Constitution); *Proffitt v. Florida*, 428 U.S. 242 (1976) (requiring the sentencing judge to consider aggravating and mitigating circumstances meets the constitutional standard for invoking the death penalty); *Jurek v. Texas*, 428 U.S. 262 (1976) (requiring the jury to find aggravating circumstances and allowing the jury to consider particularized mitigating circumstances meets the requirements of the Eighth and Fourteenth Amendments, allowing the jury to invoke the death penalty).

29. *Lockett v. Ohio*, 438 U.S. 586 (1978) (a mitigating factor is "any aspect of the defendant's character or record and any of the circumstances of the offense that the defendant proffers as a basis for a sentence less than death").

30. *Eddings v. Oklahoma*, 455 U.S. 104 (1982) (petitioner's violent family background is a relevant factor for consideration at sentencing hearing); *Penry v. Lynaugh*, 492 U.S. 302 (1986) (mitigating evidence of defendant's being abused as a child must be considered by the jury at sentencing hearing).

31. *Skipper v. South Carolina*, 476 U.S. 1 (1986) (evidence of adaptability to prison life is relevant and the defendant should not be precluded from presenting such evidence in mitigation).

32. *Eddings*, 455 U.S. at 104; *Penry*, 492 U.S. at 302 (mitigating evidence of defendant's being abused as a child must be considered by the jury at sentencing hearing).

33. *Lockett*, 438 U.S. at 586.

34. Of the thirty-eight states that currently have the death penalty, fifteen allow some consideration of future violence in sentencing determinations. Alabama does not require a finding of future dangerousness in death penalty sentencing by statute, but allows evidence to be presented "as to any matter that the court deems relevant to sentence and shall include any matters relating to the aggravating and mitigating circumstances." ALA. CODE § 13A-5-45(c) (2002). While future dangerousness is not one of the aggravating circumstances, and the Alabama Supreme Court does not allow it to be considered at the guilt stage of a trial, it does allow courts to consider it during the sentencing phase. See, e.g., *Williams v. State*, 601 So. 2d 1062 (Ala. Crim. App. 1991) (rejecting the contention that expert testimony on future dangerousness should be excluded from capital trials and holding that "[t]he rules of evidence generally extant at the federal and state levels anticipate that relevant, unprivileged evidence should be admitted and its weight left to the factfinder, who would have the benefit of cross-examination and contrary evidence by the opposing party").

In Arizona, future dangerousness is not an aggravating circumstance but expert testimony as to future dangerousness is allowed by the courts. ARIZ. REV. STAT. § 13-703

(2001). A defendant is also allowed to argue a lack of future dangerousness as a non-statutory mitigating factor. *Id.*; *see, e.g.*, *Logerquist v. McVey*, 1 P.3d 113, 127 (2000) (holding that "[i]f the jury may make up its mind about future dangerousness unaided by psychiatric testimony, jurors should not be barred from hearing the views of the State's psychiatrists along with opposing views of the defendant's doctors").

In California, future dangerousness is not a statutory aggravating factor under the California Penal Code but the courts will allow it in rebuttal or if it is a permissible inference based on the evidence. CAL. PENAL CODE § 190.3 (West 2002); *see, e.g.*, *People v. Ochoa*, 966 P.2d 442 (Cal. 1999) (even if the prosecution is prohibited from offering expert testimony predicting future dangerousness in its case-in-chief, it may explore the issue on cross-examination or in rebuttal if defendant offers expert testimony predicting good prison behavior in the future).

In Georgia, future dangerousness is not an aggravating circumstance. GA. CODE ANN. § 17-10-30 (2001). The Code does allow for the inclusion of any mitigating circumstances or aggravating circumstances otherwise authorized by law in addition to the ten included in the statute. *See, e.g.*, *Johnson v. State*, 519 S.E.2d 221 (Ga. 1999) (finding the issue of a defendant's future dangerousness relevant in the sentencing phase).

In Idaho, a sentencing jury may consider the future dangerousness of the defendant. It is one of the statutory aggravating factors: "The defendant, by prior conduct or conduct in the commission of the murder at hand, has exhibited a propensity to commit murder which will probably constitute a continuing threat to society." IDAHO CODE § 19-2515 (Michie 2002); *see, e.g.*, *State v. Fields*, 908 P.2d 1211 (Idaho 1995) (holding that the aggravating circumstance related to the defendant's continuing threat to society is not unconstitutionally vague).

In Louisiana, future dangerousness is not a statutory aggravating factor, LA. CODE CRIM. PROC. ANN. art. 905.2 (West 2002); however, the law does allow the "character and propensities" of the defendant to be considered by the jury, *id.*; *see, e.g.*, *State v. Cooks*, 720 So. 2d 637 (La. 1998) (holding that it is proper to introduce evidence of the defendant's gang-related activities because it shows future dangerousness).

In Missouri, future dangerousness is not an aggravating factor, MO. REV. STAT. § 565.032 (2001); however, the courts allow for admission of such evidence, *see, e.g.*, *State v. Chambers*, 891 S.W.2d 93 (Mo. 1994) (character and future dangerousness evidence is admissible at penalty phase).

Future dangerousness is not an aggravating circumstance under North Carolina law, N.C. GEN. STAT. § 15A-2000 (2001); however, the courts do allow the prosecutors broad latitude in raising the issue, including raising it in reference to the defendant being dangerous to fellow inmates or prison guards if he is given life without parole, *see, e.g.*, *State v. Davis*, 539 S.E.2d 243 (N.C. 2000) (evidence of future dangerousness is not improper in a sentencing hearing).

In Oklahoma, "[t]he existence of a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society" is one of the eight statutory factors considered by the sentencing court. OKLA. STAT. tit. 21 § 701.12 (2002); *see, e.g.*, *Bland v. State*, 4 P.3d 702, 725 (Okla. Crim. App. 2000) (In order to establish the aggravating circumstance that the defendant poses a continuing threat to society, the state must prove "beyond a reasonable doubt: [f]irst, that the defendant's behavior has demonstrated a threat to society; and [s]econd, a probability that this threat will continue to exist in the future.").

In Oregon, the jury must determine "whether there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society" as part of its death penalty consideration. OR. REV. STAT. § 163.150 (2001).

In Pennsylvania, future dangerousness is not a statutory aggravating circumstance. 42 PA. CONS. STAT. § 9711 (2002). Prosecutors are, however, allowed to address future dangerousness. *See, e.g.*, *Commonwealth v. Smith*, 675 A.2d 1221, 1234 n.15 (Pa. 1996) ("[D]efendant has a due process right to state-funded psychiatric assistance during the penalty phase of a death penalty case where the assistance would be useful to rebut the prosecution's assertion of the defendant's 'future dangerousness' to society") (emphasis added) (quoting *Commonwealth v. Christy*, 656 A.2d 877, 883 (Pa. 1995))).

Texas requires a finding of future dangerousness in death penalty cases. TEX. CODE CRIM. PROC. ANN. art. 37.071 (Vernon 2002). Under section 2(b) of that article, the court shall "[o]n conclusion of the presentation of the evidence . . . submit the following issues to the jury: (1) whether there is a probability that the defendant would commit criminal acts

chologist or psychiatrist to develop that evidence.³⁵ The United States Supreme Court has endorsed such use of psychiatric testimony.

In *Jurek v. Texas*, the United States Supreme Court approved the use of future dangerousness as an aggravating factor in death penalty cases.³⁶ *Jurek* is one in a series of cases decided in 1976³⁷ that approved the newly revised capital murder statutes replacing those that had been declared unconstitutional in *Furman v. Georgia*.³⁸ In approving the revised Texas statute, the Court determined that it met the requirements of the Eighth and Fourteenth Amendments because it allowed the jury to consider mitigating evidence by having them answer specific questions about the defendant and his crime. "The Texas capital-sentencing procedure guides and focuses the jury's objective consideration of the particularized circumstances of the individual offender before it can impose a sentence of death."³⁹

In addition to two other questions,⁴⁰ the revised Texas statute required

of violence that would constitute a continuing threat to society." TEX. CODE. CRIM. PROC. ANN. art. 37.071(2)(b)(1) (Vernon 2002). The state must prove future dangerousness "beyond a reasonable doubt." TEX. CODE CRIM. PROC. ANN. art. 37.071(2)(c) (Vernon 2002).

Future dangerousness is not an aggravating factor under Utah law, UTAH CODE ANN. § 76-5-202; however, section 76-3-207 allows the court to consider "any other facts in aggravation or mitigation of the penalty that the court considers relevant to the sentence," see, e.g., *State v. Young*, 853 P.2d 327 (Utah 1993). "Unlike the guilt phase of a trial, the sentencing phase revolves around the character and background of a defendant." *Id.* at 353. Further, "[a]n examination into a defendant's character is mandatory in a capital sentencing proceeding[, and a] jury may legitimately consider a defendant's character, future dangerousness, lack of remorse, and retribution in the penalty phase hearing." *Id.*

Virginia requires a consideration of future dangerousness prior to imposition of a death sentence:

In assessing the penalty of any person convicted of an offense for which the death penalty may be imposed, a sentence of death shall not be imposed unless the court or jury shall (1) after consideration of the past criminal record of convictions of the defendant, find that there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing serious threat to society or that his conduct in committing the offense for which he stands charged was outrageously or wantonly vile, horrible or inhuman in that it involved torture, depravity of mind or an aggravated battery to the victim; and (2) recommend that the penalty of death be imposed.

VA. CODE ANN. § 19.2-264.2 (Michie 2002).

In Wyoming, the sentencing jury is permitted to consider whether "the defendant poses a substantial and continuing threat of future dangerousness or is likely to commit continued acts of criminal violence." WYO. STAT. ANN. § 6-2-102 (Michie 2001).

35. "At least 121 Texas death row inmates were sentenced to death based on psychiatric testimony." *A Danger to Society*, *supra* note 9.

36. 428 U.S. 262 (1976); *A Danger to Society*, *supra* note 9.

37. See cases cited *supra* note 28.

38. 409 U.S. 402 (1972).

39. *Jurek*, 428 U.S. at 273-74.

40. The other two questions are:

"(1) whether the conduct of the defendant that caused the death of the deceased was committed deliberately and with the reasonable expectation that the death of the deceased or another would result;

(3) if raised by the evidence, whether the conduct of the defendant in killing the deceased was unreasonable in response to the provocation, if any, by the deceased."

the jury to determine "whether there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society."⁴¹ While acknowledging that it is difficult to predict the future, the Court maintained:

The fact that such a determination is difficult, however, does not mean that it cannot be made. Indeed, prediction of future criminal conduct is an essential element in many of the decisions rendered throughout our criminal justice system. The decision whether to admit a defendant to bail, for instance, must often turn on a judge's prediction of the defendant's future conduct. And any sentencing authority must predict a convicted person's probable future conduct when it engages in the process of determining what punishment to impose. For those sentenced to prison, these same predictions must be made by parole authorities. The task that a Texas jury must perform in answering the statutory question in issue is thus basically no different from the task performed countless times each day throughout the American system of criminal justice. What is essential is that the jury have before it all possible relevant information about the individual defendant whose fate it must determine.⁴²

In endorsing the future dangerousness question, the Court indicated that such an inquiry would involve evidence that may in fact be mitigating, not merely aggravating.

In determining the likelihood that the defendant would be a continuing threat to society, the jury could consider whether the defendant had a significant criminal record. It could consider the range and severity of his prior criminal conduct. It could further look to the age of the defendant and whether or not at the time of the commission of the offense he was acting under duress or under the domination of another. It could also consider whether the defendant was under an extreme form of mental or emotional pressure, something less, perhaps, than insanity, but more than the emotions of the average man, however inflamed, could withstand.⁴³

The issue of psychiatric testimony, although perhaps inherent in the idea of "mental or emotional pressure" was not directly addressed in the *Jurek* case.

Soon after *Jurek* was affirmed, prosecutors began using psychiatrists to bolster their evidence of future dangerousness.⁴⁴ In 1983, the United States Supreme Court relied upon *Jurek* to hold that psychiatrists may give expert opinions as to the future dangerousness of a capital murder defendant.⁴⁵ Thomas A. Barefoot was convicted of fatally shooting a police officer after he was apprehended as a suspect in an arson

Id. (citing TEX. CODE CRIM. PROC. ANN. art. 37.071(b)(1)(3) (Vernon Supp. 1975-1976)).

41. *Id.* (citing TEX. CODE CRIM. PROC. ANN. art. 37.071(b)(2) (Vernon Supp. 1975-1976)).

42. *Jurek*, 428 U.S. at 274-76.

43. *Id.* at 273 (citing *Jurek v. State*, 522 S.W.2d 934, 939-40 (Tex. Crim. App. 1975)).

44. See, e.g., *A Danger to Society*, *supra* note 9.

45. *Barefoot v. Estelle*, 463 U.S. 880 (1983).

investigation.⁴⁶

At trial, two psychiatrists testified for the prosecution. Neither psychiatrist had personally evaluated the defendant or performed any psychological testing to determine whether he suffered from a mental illness at the time of the crime. Yet based on a hypothetical presented by the prosecutor that detailed the evidence against Mr. Barefoot, both psychiatrists testified that he would be a continuing threat to society.⁴⁷ Dr. Holbrook diagnosed Mr. Barefoot "as a criminal sociopath. He testified that he knew of no treatment that could change this condition, and that the condition would not change for the better but 'may become accelerated' in the next few years."⁴⁸ Dr. Holbrook opined that Mr. Barefoot would commit violent crimes in the future and was a threat to society, "and that his opinion would not change if the 'society' at issue was that within Texas prisons rather than society outside prison."⁴⁹

Dr. Grigson also testified based on the hypothetical that Mr. Barefoot had "a fairly classical, typical, sociopathic personality disorder He placed Barefoot in the 'most severe category' of sociopaths (on a scale of one to ten, Barefoot was 'above ten'), and stated that there was no known cure for that condition."⁵⁰ Dr. Grigson likewise testified that even if Mr. Barefoot remained in prison, there was a "one hundred percent and absolute chance that Barefoot would commit future acts of criminal violence that would constitute a continuing threat to society."⁵¹

In essence, both doctors testified that Mr. Barefoot's "sociopathic personality disorder" deprived him of free will. Presumably, Mr. Barefoot could never abstain from killing again because of his diagnosis. Such a conclusion lacks a scientific foundation⁵² and contradicts the criminal justice premise that individuals are punished for their volitional behavior.⁵³ Without any scientific reliability inquiry prior to their testimony, both doctors were allowed to testify as to their scientific conclusions.

These extremely damaging scientific predictions of certain future violence were admitted into evidence without any foundation being laid to demonstrate the reliability of the predictions or the acceptance of the practice of predicting future dangerousness in psychiatry. The admissibility of the psychiatrists' testimony was upheld despite the fact that the American Psychiatric Association (the "APA") filed an amicus brief stating that "the unreliability of psychiatric predictions of long-term future

46. *Barefoot v. State*, 596 S.W.2d 875, 878 (Tex. Crim. App. 1980).

47. *Id.* at 887.

48. *Barefoot*, 463 U.S. at 919 (Blackmun, J., dissenting).

49. *Id.* at 919.

50. *Id.*

51. *Id.*

52. Widiger & Trull, *supra* note 19, at 203-26; Dale E. McNiel, *Hallucinations and Violence*, in *VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT* 194 (John Monahan & Henry Steadman eds., 1994).

53. "The legal paradigm is constructed around assumptions of free will and individual responsibility" FAIGMAN ET AL., *supra* note 14, at 2.

dangerousness is by now an established fact within the profession.”⁵⁴ In addition, the APA’s brief noted, “two out of three predictions of long-term future violence made by psychiatrists are wrong.”⁵⁵

In dismissing the claim that psychiatrists’ are incompetent to reliably predict the future, the Court implies that such testimony is widely accepted in this context. “The suggestion that no psychiatrist’s testimony may be presented with respect to a defendant’s future dangerousness is somewhat like asking us to disinvent the wheel.”⁵⁶ In fact, while psychiatric testimony as to future behavior may have been accepted in other contexts, the Court had never before permitted its use in a capital murder trial. The “wheel” of capital murder statutes had in fact been re-invented at the time of the *Jurek* decision—a decision that heralded the arrival of the modern death penalty.

The Court’s decision in *Barefoot* also failed to distinguish between expert opinion testimony and lay decisions about the defendant’s future dangerousness.

[I]f it is not impossible for even a lay person sensibly to arrive at that conclusion [that the defendant will be a danger in the future], it makes little sense, if any, to submit that psychiatrists, out of the entire universe of persons who might have an opinion on the issue, would know so little about the subject that they should not be permitted to testify.⁵⁷

Here, the Court confuses expert opinion testimony with jury decisions. It does not follow that because a jury must make a prediction about the defendant’s behavior that any and all witnesses are likewise permitted to do so.

Essentially, the Court fails to acknowledge that the only reason the psychiatrists are permitted to testify as to opinion, instead of being limited only to facts as all other witnesses are, is because they are qualified as experts and therefore have some expertise in this area outside the realm of everyday knowledge.⁵⁸ Surely the Court does not mean that the psychiatrists’ uneducated guesses are as good as anyone else’s, and thus anyone’s speculation, feelings, or theory about the defendant’s future conduct is admissible at the penalty phase of a capital murder trial. Would the Court have allowed the testimony to go forward if a police detective, qualified as an expert because of his years of experience with criminals, were called to testify as to the future dangerousness of the defendant? What about a plumber, qualified as an expert to explain the location of the pipes in the burning building—could he also opine about the defendant’s propensity for violence?

54. *Barefoot*, 463 U.S. at 920 (Blackmun, J., dissenting) (citing American Psychiatric Association Amicus Curiae Brief, at 12).

55. *Id.* (citing American Psychiatric Association Amicus Curiae Brief, at 9, 13).

56. *Id.* at 896.

57. *Id.* at 896-97.

58. “In neither *Barefoot* nor in *Jurek* did the Court specifically explain why unreliable expert testimony was admissible to assist the jury.” FAIGMAN ET AL., *supra* note 14, at 84.

In addition, the Court's comment about not excluding only psychiatrists "out of the entire universe of persons who might have an opinion on the issue," ignores the fact that even if all other persons have an opinion on the defendant's propensity to commit violence, those persons are not permitted to testify. Opinion testimony, absent expert qualification, is inadmissible in court.⁵⁹ A jury draws conclusions from listening to facts, not lay opinions. It may be that the entire universe of persons has an opinion that the defendant is in fact guilty. Nevertheless, not a single one of those persons will be allowed to testify regarding his or her opinion.

Even though the Court acknowledged that there was no psychiatric testimony in *Jurek*, it still confuses these two issues. The Court stated, "Although there was only lay testimony with respect to dangerousness in *Jurek*, there was no suggestion by the Court that the testimony of doctors would be inadmissible."⁶⁰ While there was testimony in *Jurek* about the defendant's past history of violence, there was none about his future dangerousness. This is an important distinction. Past violence is provable by facts and demonstrated either by specific criminal convictions (such as prior murders, assaults, rapes) or by unindicted but still extremely specific prior bad acts (witnesses who testify as to defendant's reputation for violence, descriptions of assaults, etc.). Open-ended predictions of future violence are merely a guess⁶¹—whether the guess is made by a layperson or a psychiatrist.

In fact, three years before *Barefoot*, the Court had recognized that psychiatrists were not necessary for predicting future dangerousness. "While in no sense disapproving the use of psychiatric testimony bearing on the issue of future dangerousness, the holding in *Jurek* was guided by recognition that the inquiry mandated by Texas law does not require resort to medical experts."⁶² Indeed, in Justice Blackmun's dissent in *Barefoot*, he noted:

Lay testimony . . . would not raise this substantial threat of unreliable and capricious sentencing decisions, inimical to the constitutional standards established in our cases; and such predictions are as accu-

59. STEVEN LUBET, MODERN TRIAL ADVOCACY: ANALYSIS AND PRACTICE (2d ed. 1997).

[L]ay witnesses must testify from personal knowledge, and they may not offer opinions. Expert witnesses comprise an entirely different category. An expert witness is not limited to personal knowledge and may base her testimony on information that was gathered solely for the purpose of testifying in litigation. Moreover, under the proper circumstances an expert witness may offer an opinion that goes well beyond her direct sensory impressions.

Id.

60. *Barefoot*, 463 U.S. at 897.

61. "Courts ordinarily do not require mental health experts to specialize in predicting violent behavior. Instead, they assume that all psychologists and psychiatrists are capable of making this determination" FAIGMAN ET AL., *supra* note 14, at 80.

62. *Estelle v. Smith*, 451 U.S. 454 (1980) (order vacating a death sentence was affirmed because defendant had not been advised of his Fifth Amendment right to remain silent before being interviewed by a court-ordered psychiatrist prior to the sentencing phase of his trial, and had been denied his Sixth Amendment right to counsel when his counsel had not been advised that future dangerousness would be considered by the psychiatrist).

rate as any psychiatrist could make. Indeed, the very basis of *Jurek* as I understood it, was that such judgements *can* be made by laymen on the basis of lay testimony.⁶³

Such lay testimony, already considered by jurors in deciding the dangerousness question, would obviously include prior violent crime by the defendant, the circumstances surrounding the offense, the defendant's remorse or lack thereof, and the defendant's reputation. An expert in psychiatry or psychology is completely unnecessary for interpretation of such factors.

As a result of these decisions, psychiatric evidence of future dangerousness is now routinely introduced in capital murder trials.⁶⁴ "At least 121 Texas death row inmates were sentenced to death based on psychiatric testimony."⁶⁵ Psychiatrists may even testify about future dangerousness from evidence gleaned during competency and insanity evaluations⁶⁶ after obtaining a Sixth Amendment waiver from the defendant. Yet the reliability of such predictions remains quite weak.⁶⁷

B. CIVIL COMMITMENT

The second major group of cases in which courts rely upon psychiatric predictions of an individual's likelihood to become dangerous are civil commitment hearings.⁶⁸ A civil commitment hearing occurs when a request is made to a court to order an individual into psychiatric treatment over the individual's objections or without the individual's consent.⁶⁹ While laws vary from state to state on the specific criteria and procedures, they all share some similarities.

First, all civil commitment schemes include a definition of mental ill-

63. *Barefoot*, 463 U.S. at 938 (Blackmun, J., dissenting) (emphasis added).

64. "Courts uniformly assume that psychiatrists and psychologists are qualified to predict future dangerousness." FAIGMAN ET AL., *supra* note 14, at 80.

65. *A Danger to Society*, *supra* note 9.

66. See, e.g., *Powell v. Texas*, 492 U.S. 680 (1989).

67. See discussion *infra* Part II.B; see also FAIGMAN ET AL., *supra* note 14, at 79 ("Most courts either entirely ignore evidentiary standards for expert testimony concerning future violence, or give it scant attention.").

68. The discussion of civil commitment in this article does not include Sexually Violent Predator Acts. Such commitment schemes are separate from traditional ones, the individuals are not always put in therapeutic settings, and the commitments can be for an indefinite time period. See, e.g., *Kansas v. Hendricks*, 521 U.S. 346 (1997) (holding that the Kansas Act allowing a pedophile to be involuntarily committed beyond his prison sentence is not a violation of the prisoner's due process rights, nor does it violate the Constitution's prohibition against double jeopardy). Because these schemes differ in so many respects from the civil commitment for mental illness, they are outside the scope of this article.

69. Catatonic individuals cannot express either objections or agreement:

Withdrawing, remaining quietly in one place for long periods, and immobility are all common behaviors in this illness. The extreme versions of such behaviors are catatonia, where the person remains rigidly fixed in one position for long periods of time, and mutism, where the person does not speak at all.

E. FULLER TORREY, *SURVIVING SCHIZOPHRENIA* 74 (4th ed. 2001).

ness, but they range widely in what that definition encompasses.⁷⁰ Second, a state typically defines who can request a petition. Such definitions may include any witness to a mentally ill individual's erratic behavior, any relative of the individual, police officers, mental health workers, and prosecutors. Third, a psychologist or psychiatrist usually testifies at the hearing.⁷¹ Fourth, each statute provides continuing judicial review for extensions of time after the initial hospitalization.⁷² Fifth, each state defines what elements must be proven to result in a civil commitment, but every state has a "dangerousness" element.⁷³

The dangerousness element permits an individual to be civilly committed if, as a result of his mental illness, he is likely to become violent in the near or reasonably predictable future. Civil commitment schemes typically require that the patient be likely to harm either himself or herself or others,⁷⁴ and some include damage to property as part of the consideration.⁷⁵ The standards for "likely to become" dangerous generally require that the violence will occur almost immediately.⁷⁶

At civil commitment hearings, the dangerousness requirement minimizes the importance of the psychiatric diagnosis and exaggerates the inquiry into the plausibility and rationality of the specific violent threat or act. Bypassing the diagnosis itself, since mental illness alone is not enough for involuntary psychiatric treatment,⁷⁷ the hearing degenerates

70. See Joanmarie Ilaria Davoli, *Still Stuck in the Cuckoo's Nest: Why do Courts Continue to Rely Upon Antiquated Mental Illness Research?*, 69 TENN. L. REV. 987, 1033 n.248 (2002) (providing a survey of various terms used by state codes to define mental illness).

71. See FAIGMAN ET AL., *supra* note 14, at 78.

72. See, e.g., OKLA. STAT. tit. 43A, § 5-420 (2002) ("Review of status of persons involuntarily committed for treatment."). Oklahoma, for example, requires a judicial review of an involuntarily committed person's status every three months, and requires that the Department of Mental Health and Substance Abuse Services take action based upon the review. *Id.*

73. Each state has a requirement relating to dangerousness or future violence. See, e.g., ALA. CODE § 22-52-37(7) (2002) (respondent "poses a real and present threat of substantial harm to himself or to others"); ALASKA STAT. § 47.30.700 (Michie 2001) (respondent presents "a likelihood of serious harm to self or others"); ARIZ. REV. STAT. § 36-540 (2001) (requiring clear and convincing evidence that respondent is a danger to himself or others); ARK. CODE ANN. § 20-47-207 (Michie 2001) (respondent presents "a clear and present danger to himself" or others); CAL. WELF. & INST. CODE § 5250 (West 2001) (requiring a finding of "present dangerousness").

74. See sources cited *supra* note 73 (reflecting the fact that each state requires a showing that the respondent is likely to harm either self or others).

75. E.g. N.J. REV. STAT. § 30:4-27.1 (2002) (requiring a showing of "dangerous to themselves, to others or to property"); N.D. CENT. CODE § 25-03.1-02 (2002) (requiring a showing of "serious risk of harm to that person, others or property").

76. E.g. GA. CODE ANN. § 37-3-1 (2001) (requiring imminent danger); VA. CODE ANN. § 37.1-67.3 (Michie 2001) (requiring imminent danger); HAW. REV. STAT. § 334-60.2 (2001) (considering if the respondent is "imminently dangerous"); 405 ILL. COMP. STAT. 5/1-119 (2001) (requiring dangerousness in the "near future"); NEV. REV. STAT. § 435.128 (2001) (considering if there exists a "clear and present danger"); OHIO REV. CODE ANN. § 5122.01 (Anderson 2002) (considering the "immediate risk"); UTAH CODE ANN. § 62A-12-234 (2000) (considering the "immediate danger").

77. As this author noted in an earlier article, the United States Supreme "Court's analysis of the liberty interest in the due process claim has practically resulted in a 'right to be crazy.'" Davoli, *supra* note 70, at 1015-16.

into an almost surreal analysis of the meaning of the specific behaviors and comments of the patient.

Typical of this misplaced emphasis is the case of *In re Retention of Boggs*.⁷⁸ After a middle-class childhood, Joyce Brown graduated from business school and worked ten years as a secretary.⁷⁹ She subsequently developed schizophrenia and began calling herself Billie Boggs.⁸⁰ For over a year she lived on the public sidewalk in New York City defecating and urinating on herself and on the street; begging; tearing up paper money; wearing filthy, torn clothing; and screaming insults at passers-by.⁸¹ She was detained by city authorities, and a civil commitment hearing was held to determine whether she should be involuntarily hospitalized.⁸²

At the hearing, the judge was presented with both defense and government psychiatrists whose testimony conflicted.⁸³ Instead of critically assessing the credibility of the various experts' testimony,⁸⁴ the lower court decided to ignore all the expert evidence⁸⁵ and instead "place[d] great weight on the demeanor, behavior and testimony of Joyce Brown [a.k.a. Billie Boggs], herself."⁸⁶ The court then analyzed each part of the evidence in a vacuum, discounting completely the diagnosis of schizophre-

For the families of the mentally ill, the biggest shock of all is to discover that the law supports the inalienable right of their family members to be crazy. If a son or daughter becomes ill as a teenager, and is covered by a parent's insurance, in the initial phase of the illness he or she will in all probability be treated. But as the illness recurs, families feel the impact of the deranged legal system established by the mental health bar. They discover that unless an individual is "dangerous," he cannot be treated against his will. The catch-22 is that the diseased organ is the brain, with the result that a very high proportion of the mentally ill do not recognize there is anything wrong with them. Their delusions are convincing and real to them, offering an explanation for their distorted perceptions of reality. RAELE JEAN ISAAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS* 249 (1990).

78. 522 N.Y.S.2d 407, 410 (N.Y. App. Div. 1987).

79. Margo Hornblower, *Down and Out—But Determined; Does a Mentally Disturbed Woman Have the Right to be Homeless?*, TIME, Nov. 23, 1987, at 29.

80. *Id.*

81. 522 N.Y.S.2d at 408.

82. *Id.*

83. *Id.* at 408-09.

84. In contrast, the appellate court analyzed both the evidence reviewed by the experts and the conclusions drawn from that evidence. "Moreover, Ms. Boggs pursued a pattern of lying to both the respondents' psychiatrists as well as her own psychiatrists In this connection, Ms. Boggs misled these psychiatrists." *Boggs v. N.Y. City Health & Hosp. Corp.*, 132 A.D.2d 340, 365 (N.Y. 1987).

85. "In short, the psychiatric experts do not agree. In fact, the doctors are nearly diametrically opposed in their assessment of Joyce Brown's mental condition and in their predictions as to whether she is likely to cause herself or others harm. Thus, I derive little psychiatric guidance from them" *In re Retention of Boggs*, 522 N.Y.S.2d at 410.

86. *Id.* In fact, the appellate court found this to be erroneous:

We find that the Hearing Court erred in placing 'great weight on the demeanor, behavior and testimony' of Ms. Boggs, since the Hearing Court does not claim that the demeanor and behavior of Ms. Boggs, when she appeared before it, remotely resembled the demeanor and behavior she exhibited when she lived on the streets, and was involuntarily committed to Bellevue.

Boggs, 132 A.D.2d at 364.

nia,⁸⁷ paranoid type.⁸⁸

As for the psychiatrists' opinion that Ms. Brown's habit of tearing up cash resulted from delusions, the court disagreed. Instead, the court accepted her two explanations that, (1) "she perceives those who offer her money as people trying to exercise control over her . . . [and burning it] was her way to dispel the control,"⁸⁹ and (2) "she saw the offerers as

87. Schizophrenia is a serious mental illness:

Diagnostic criteria for Schizophrenia

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- (1) delusions
- (2) hallucinations
- (3) disorganized speech (e.g., frequent derailment or incoherence)
- (4) grossly disorganized or catatonic behavior
- (5) negative symptoms, i.e., affective flattening, alogia, or avolition

NOTE: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: For a significant portion of time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level or interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance /general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

DSM-IV, *supra* note 16, at 285-86.

88. *In re Retention of Boggs*, 522 N.Y.S.2d at 408. For the specific type of schizophrenia:

Diagnostic criteria for 295.30 Paranoid Type. A type of Schizophrenia in which the following criteria are met:

- A. Preoccupation with one or more delusions or frequent auditory hallucinations.
- B. None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.

DSM-IV, *supra* note 16, at 287.

89. 522 N.Y.S.2d at 409.

Black males, whether they were or not, who wanted to buy sex. The destruction of the currency was her attempt to purge herself of the taint of prostitution and elicit respect.”⁹⁰ During her hearing, Ms. Brown testified that she “prefers to have no money on her person at night because it’s dangerous.”⁹¹ Although the court found nothing delusional about perceiving non-black, non-male individuals to in fact be black men, it admirably noted that while her explanation for tearing up money “may not satisfy a society increasingly oriented to profit making and bottom-line pragmatism, . . . it is consonant with safe conduct on the street and consistent with the independence and pride she vehemently insists on asserting.”⁹² The court concluded its analysis of Ms. Brown’s destruction of cash with the boasting flourish that “apparently, beggars can be choosers.”⁹³

In considering Ms. Brown’s explanation for urinating and defecating on the sidewalk, the court accepted her argument that the lack of public bathrooms necessitated this behavior. “There being no public toilets except at Grand Central and Pennsylvania Stations, both of which are too distant from her post, she urinates and defecates on the street, though, she insists, never on herself, while covering herself with a coat.”⁹⁴ Reliance upon this explanation to discount the shocking, socially repugnant, unhealthful, exhibitionist aspects of this behavior strikes the reader as fanciful.

In reality, it was Ms. Brown’s mental illness that reduced her inhibitions⁹⁵ and compelled her to live on the street in a Manhattan shopping district without access to bathrooms that resulted in this behavior. Yet, the court accepted her testimony that bathrooms were unavailable without inquiring into any efforts Ms. Brown made to locate a non-public place for defecating and urinating. Instead of critically assessing Ms. Brown’s testimony, the courts mused that “to the passerby seeing her lying on the street or defecating publicly she may seem deranged But how can anyone living in security and comfort even begin to imagine what is required to survive on the street?”⁹⁶ The court thus accepted the explanation that society’s failure to provide public bathrooms wherever Ms. Brown wandered, and not Ms. Brown’s delusions, forced her to defecate and urinate publicly.

Even though testimony was given describing an incident in which Ms. Brown ran into traffic, the court accepted her decision as discounting any possibility that she might harm herself. As the facts were in dispute, the

90. *Id.*

91. *Id.* at 410.

92. *Id.* at 411.

93. *Id.*

94. *Id.* at 410.

95. “A small number of patients are so ill that they continue inappropriate behaviors (such as random urination, open masturbation, spitting on others) even in public.” TORREY, *supra* note 69, at 77.

96. *In re Retention of Boggs*, 522 N.Y.S.2d at 412.

court determined that Ms. Brown's behavior was provoked by city authorities who attempted to render her assistance.

[The court noted that Ms. Brown] resented [the social workers'] presence, their help, their conversation, their offer of food and clothes. Their persistent, often rejected assistance and their 'bad' manner of treating her and speaking to her aroused her anger and prompted her abusive, obscene language. One day she threw the pants they gave her into the street. This is the occasion referred to by the hospital psychiatrists when they allude to her running into moving traffic. According to Ms. Brown, she stepped into the parking lane, not the traffic lane.⁹⁷

The court found this explanation rational and compelling, and completely discounted any possibility that Ms. Brown's behavior was either dangerous or resulted from her mental illness.⁹⁸ "As to the likelihood that she would cause herself serious bodily harm, no proof has been offered to substantiate the claim. The fear that she may provoke others to cause her harm is without substantiation in her past history."⁹⁹

The court further assessed Ms. Brown's ability to meet her basic physical needs of food, clothing, and shelter. Her need for food was satisfied by her begging for money and then buying one meal a day.¹⁰⁰ While admitting that Ms. Brown lived on the street "barefooted and dressed in filthy, tattered, foul-smelling clothes,"¹⁰¹ this met the basic requirement for clothes. "The legal question before me is whether Joyce Brown is mentally capable of providing herself with clothes; the question is not whether she is financially able to do so."¹⁰² Yet the court failed to realize that if Ms. Brown didn't tear up all paper money, she could probably afford clean, non-tattered, fresh smelling clothes.¹⁰³ The court completely ignored the effect of her mental illness on her choice of attire.

For shelter, Ms. Brown had kept "warm by lying next to an air vent that releases hot air 24 hours a day. The street is her bedroom, her toilet, her living room."¹⁰⁴ Once again, the court blamed society for creating a need for Ms. Brown to reject all other options and reside next to a heating vent.¹⁰⁵ Without referring to any supporting testimony, the court deter-

97. *Id.* at 410.

98. "I accept Ms. Brown's version that she did not place herself in the line of moving traffic." *Id.* at 411.

99. *Id.* at 412.

100. "With money she gets from panhandling, she buys one meal everyday at a neighborhood store. This meal, the same daily, is comprised of a chicken cutlet, juice, milk and ice cream." *Id.* at 408.

101. *Id.* at 412.

102. *Id.*

103. See *supra* text accompanying notes 89-94.

104. *In re Retention of Boggs*, 522 N.Y.S.2d at 408.

105. In fact, the appellate court also noted the fallacy of this interpretation of Ms. Brown's homelessness. "We reject, as against the weight of the evidence, the Hearing court's conclusion that, in substance, Ms. Boggs' homelessness is not a result of serious mental illness, but, rather, is the result of New York's lack of housing for the poor." *Boggs v. N.Y. City Health & Hosps. Corp.*, 132 A.D.2d 340, 365 (N.Y. 1987).

mined that “[h]ousing in New York is an expensive commodity, so expensive that in this rich city many no longer can afford it and are driven to live on the street.”¹⁰⁶ There was, however, no such evidence that poverty produced Ms. Brown’s homelessness.

Not only was society’s callousness to blame for forcing Ms. Brown to live on the streets, but the court further determined that there were no reasonable alternatives. Ms. Brown “refuses to be housed in a shelter. That may reveal more about conditions in shelters than about Joyce Brown’s mental state. It might, in fact, prove that she’s quite sane. She refuses confinement in Bellevue’s psychiatric facilities, preferring freedom on the street with all its attendant risks.”¹⁰⁷ Thus, Ms. Brown’s untreated mental illness didn’t reduce her to a filthy, begging, street person. The court faulted society: “I am aware her mode of existence does not conform to conventional standards, that it is an offense to aesthetic senses. It is my hope that the plight she represents will also offend moral conscience and rouse it to action.”¹⁰⁸

In addition, the court revealed its stereotypical bias that mental illness strikes only the uneducated and depraved,¹⁰⁹ when it gushingly remarked, “throughout her testimony, Ms. Brown was rational, logical, coherent. Her use of English, both in syntax and vocabulary, is very good and bespeaks an educated, intelligent person. She displayed a sense of humor, pride, a fierce independence of spirit, quick mental reflexes.”¹¹⁰ The court did not explain, however, how qualities such as speaking proper English or having a sense of humor, reveal any evidence of whether a person is afflicted with a mental illness.

Another example of the reduced importance of a mental illness diagnosis and the exaggerated emphasis on predicting future violence occurs in the Pennsylvania civil commitment scheme.¹¹¹ In *Gibson v. DiGiacinto*,¹¹² the Supreme Court of Pennsylvania reversed and remanded the involuntary commitment of Russell Gibson. After reviewing the evidence of dangerous behavior, the court determined that none of Mr. Gibson’s actions satisfied the commitment requirements, and reversed the lower court.¹¹³

In its analysis, the Pennsylvania Supreme Court quickly brushed past the testimony of a psychiatrist that Mr. Gibson is a “schizophrenic with

106. *In re Retention of Boggs*, 522 N.Y.S.2d at 412.

107. *Id.*

108. *Id.*

109. “Other surveys have reported that many people continue to believe that schizophrenia and other severe psychiatric disorders are caused by sin or weakness of character.” TORREY, *supra* note 69, at 387. See generally OTTO F. WAHL, *MEDIA MADNESS: PUBLIC IMAGES OF MENTAL ILLNESS* (1995).

110. 522 N.Y.S.2d at 412.

111. See Steven B. Datlof, *The Law of Civil Commitment in Pennsylvania: Towards a Consistent Interpretation of the Mental Health Procedures Act*, 38 DUQ. L. REV. 1 (1999) (providing a comprehensive discussion of the Pennsylvania civil commitment laws).

112. *Com. ex rel. Gibson v. DiGiacinto*, 439 A.2d 105 (Pa. 1981).

113. *Id.* at 107.

paranoid delusions . . . [and] that appellant poses a clear and present danger to himself and others.”¹¹⁴ In fact, the supreme court seemed to ignore major portions of the transcript cited by the lower court. “He related that voodoo spirits were bothering him, people on the street were putting voodoo on him, naked women were coming in and trying to rape him He was very, very emotionally disturbed.”¹¹⁵ Separating the actions of the appellant from his diagnosis, the supreme court suggested explanations for the dangerous behavior that were wholly unsupported by the evidence.

For example, the court dismissed as benign evidence that Mr. Gibson had burned a newspaper in his cell. “There is no evidence of attempted suicide or self-mutilation. The burning newspaper in appellant’s cell cannot be viewed as such an attempt. Appellant was permitted to smoke”¹¹⁶ Yet, the guard’s actual testimony, cited in the lower court opinion but not mentioned by the higher court, was that “[a]s I opened the cell, there was smoke . . . Russell stamped out the fire. At that time, he picked up a newspaper which was folded up and was approximately burned one-quarter of the way . . . there [were no other inmates] in Russell’s cell at that time.”¹¹⁷ While burning a newspaper in a jail cell may not conclusively prove anything, the court’s willingness to invent an explanation is striking. The court doesn’t refer to any testimony that the newspaper was burning because Mr. Gibson was careless, or using it to light cigarettes, or any other reason. The court appears to have seized upon any reasonable explanation—even one not advanced during testimony—as plausible enough to dismiss the obvious conclusion that burning a newspaper in a jail cell is potentially dangerous behavior.

The higher court dismissed evidence that Mr. Gibson possessed a twisted piece of coat hanger discovered during a search. “Appellant’s possession of the piece of coat hanger allegedly fashioned into a weapon was also not a proper basis for commitment. There was no testimony that appellant used or threatened to use the hanger to injure himself or others.”¹¹⁸ Yet, the lower court cited testimony that the coat hanger was “bent out with the screw end out and the back part made so you could grip it. It would be a very, very vicious weapon if you got it in the belly or stomach.”¹¹⁹

Additionally, the lower court cited several threats made by Mr. Gibson, including the fact that his delusions contained persecution and retaliation features. One psychiatrist testified that Mr. Gibson “believed that people are against him and they want to kill him and he, in turn, had to kill them.”¹²⁰ He elaborated that Mr. Gibson described “a kind of survival or

114. *Id.* at 106.

115. *Com. ex rel. Gibson v. DiGiacinto*, 395 A.2d 938, 940 (Pa. Super. Ct. 1978).

116. *Com. ex rel. Gibson*, 439 A.2d at 107.

117. *Com. ex rel. Gibson*, 395 A.2d at 940.

118. *Com. ex rel. Gibson*, 439 A.2d at 107.

119. *Com. ex rel. Gibson*, 395 A.2d at 940.

120. *Id.* at 942.

self-survival games. In other words, he thought that others were hurting him, so to prevent it, he has to kill the person that survives.”¹²¹ Combined with a specific threat to a guard,¹²² testimony that Mr. Gibson was “knocking furniture around,”¹²³ and possession of a weapon would seem to satisfy the overt act requirement of the Pennsylvania code. However, the higher court decided that none of the evidence “constituted the overt act required”¹²⁴ for commitment.

Despite evidence that Mr. Gibson suffered from severe delusions, the higher court also ignored his refusal to take his antipsychotic medications. The lower court noted the psychiatrist’s testimony that, “he was not comprehending realities . . . he was hearing things from other sources . . . he believed that people are controlling his mind and then making him sick.”¹²⁵ Yet, the appellate court emphasized that there “was no evidence to show that his behavior changed as a result of missed doses” of medication. The court’s analysis seems to purposely ignore the connection between refusal of medications and increase of psychotic symptoms such as delusions.

The cases of Billie Boggs and Russell Gibson demonstrate that, instead of recognizing a causal connection between the delusional individual’s behavior and the diagnosis of mental illness, the courts tend to analyze the two separately. This analysis ignores that the rationale for civil commitment is to provide treatment for an afflicted individual, and appears to reflect a suspicion of psychiatry. Both cases reveal that courts sometimes invent reasonable explanations for odd behavior, even without supporting evidence.¹²⁶ Once a court seizes upon any plausible explanation, instead of acknowledging that mentally ill individuals sometimes act irrationally, the civil commitment is usually dismissed.

C. FLAWED PREMISES IN VIOLENCE PREDICTION

The courts’ reliance upon psychiatric predictions of violence in capital punishment and the reluctance to accept it in civil commitment hearings are both based on different but equally flawed premises. In capital punishment, the flaw underlying the admissibility of such testimony is the fiction that the capital murder defendant has somehow lost his ability to exercise free will and make the choice of whether to re-offend. Because the psychiatrist has no more insight into what future choices the defen-

121. *Id.* at 943.

122. *Id.* (Gibson said, “Well, somebody sent me to Fairview. You’re going to pay.”).

123. *Id.* at 941.

124. *Com. ex rel. Gibson v. DiGiacinto*, 439 A.2d 105, 107 (Pa. 1981).

125. *Com. ex rel. Gibson*, 395 A.2d at 942.

126. See *supra* notes 104-06 and accompanying text (relating that the court surmised that Joyce Brown’s homelessness was probably caused by the high cost of housing in New York City); *supra* notes 116-18 and accompanying text (relating that the court found that Russell Gibson’s being allowed to smoke cigarettes somehow explained his possession of a burning newspaper).

dant will make than the common man, such testimony lacks reliability and relevancy.

Likewise, in civil commitment hearings, the flawed premise underlying the marginalization of psychiatric testimony is the fiction that the individual will act rationally despite the fact that he is delusional. Thus, ignoring the fact that a psychiatrist has testified that a patient is likely to become violent *as a result of his mental illness*, these hearings tend to bog down on the plausibility of the patient's plan for violence or on the inconsistencies in his threats.¹²⁷ Once the patient begins to act on his delusions and hallucinations, discussions of rational behavior become irrelevant.

Traditional legal standards for mental illness envision a person suffering from a problem that robs him of free will.¹²⁸ This rationale underlies both the defense of not guilty by reason of insanity¹²⁹ and the requirement that a defendant be competent to stand trial.¹³⁰ The legal test for competency may vary slightly among jurisdictions, but in essence, competency requires that the individual be aware of what is occurring at the present time, understands the ramifications of his decisions, and can exercise free will in making current decisions. Likewise, the theory inherent

127. See, e.g., TORREY, *supra* note 69, at 174-209.

Individual horror stories abound of clearly psychotic persons who could not be involuntarily placed in treatment because of the stringent interpretation given to 'dangerousness to self or others' by law enforcement and judicial officials In Wisconsin, 'a man barricaded himself in his house and sat with a rifle in his lap muttering Kill, kill, kill. A judge ruled that the man was not demonstrably violent enough to qualify for involuntary commitment.'

At another commitment hearing in Wisconsin, a man with schizophrenia, already mute and refusing to eat food or bathe, was observed to be eating feces while being held in jail. He was released because such behavior did not qualify as dangerous. The dialogue at the commitment hearing included the following:

Public defender: Doctor, would the eating of fecal material on one occasion by an individual pose a serious risk of harm to that person?

Doctor: It is certainly not edible material It contains elements that are considered harmful or unnecessary.

Public defender: But, Doctor, you cannot state whether the consumption of such material on one occasion would invariably harm a person?

Doctor: Certainly not on one occasion.

The public defender then moved to dismiss the action on the grounds that the patient was in no imminent danger of physical injury or dying, and the case was dismissed.

Id. at 189-90.

128. "[T]he underlying principle associated with insanity, lack of responsibility for 'involuntary' actions is ancient. Excusing, and then treating, the insane for their antisocial acts and violent propensities is, perhaps, the mark of a civilized society." FAIGMAN ET AL., *supra* note 14, at 4.

129. "The criminal law assumes 'free will,' the capacity to make and act upon choices. But the law is also willing to assume that mental disability reduces this capacity, thus making the person less blameworthy and less able to obey the law's mandates." RALPH REISNER & CHRISTOPHER SLOBOGIN, *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 496 (2d ed. 1990).

130. *Dusky v. United States*, 362 U.S. 402 (1960) ("[T]he test [for competency] must be whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and . . . a rational, as well as factual understanding of the proceedings against him.").

in every standard for the insanity defense¹³¹ is that the individual is unable to exercise free will because of a mental illness. The theory of the insanity defense is that, but for the mental illness, the crime would have never been committed.

Psychiatry, however, does not limit itself to disorders that prevent the exercise of free will. Psychiatry studies both brain and personality disorders.¹³² Because every single one of our actions and thoughts are controlled by our brains,¹³³ there is psychiatric research on a wide variety of issues. Yet many of these issues have no relevance in predicting violence, or merely reflect common sense views on the topic. Substance and alcohol abuse are two examples.

While an addiction may be a relevant issue in mitigation, it is not a defense to a crime. A criminal defendant cannot successfully assert cocaine addiction as an insanity defense to a charge of cocaine possession.¹³⁴ However, psychiatric studies routinely include in their definition of mental illness individuals who are substance abusers but suffer from no other disorder.¹³⁵ Such studies about the rate and frequency of mental illness contribute to the mistaken idea that psychiatrists possess the ex-

131. "Jurisdictions have experimented with a wide assortment of insanity tests, ranging from the M'Naghten right/wrong test to the Durham product rule; still other jurisdictions have experimented by adding categories to the insanity defense, such as not guilty by reason of insanity." LUBET, *supra* note 59, at 21.

132. Stephen J. Morse, *Crazy Behavior, Morals & Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 605 (1978).

The first reason for limiting [psychiatric] experts to descriptions of behavior is that their conclusions are based, in part, on mental health diagnostic categories that are generally overinclusive. These categories are much broader than the crazy behaviors that seem to compel special legal treatment. The various disorder categories delineated by both the present and proposed diagnostic manuals of the American Psychiatric Association may be ranged along a quantitative and qualitative continuum of craziness. Some categories seem to describe behavior that would be considered quite crazy, at least in its extreme forms, by anyone. Others describe behavior that would not be considered crazy and, at worst, would be considered normally quirky.

Id. at 605.

133. BBC Online, BRAINSTORY, (Aug. 22, 2000) http://www.bbc.co.uk/science/humanbody/articles/general/brainstory_brainbasics.shtml.

On average the human brain weighs only 1.3Kg. Yet this mass of gray blanch-mange is central to everything we do. It is the home of our thoughts, our memories and our emotions. It controls the activities of our bodies and allows us to experience the senses of touch, taste, sight, sound and smell. The brain is made up of around 100,000,000,000 (100 billion) cells known as neurons. Each neuron has up to 10,000 connections to other neurons within the brain. These connections are known as synapses. Everything we do . . . is controlled by our brain's circuitry.

Id.

134. A defendant also may not be found guilty for being a drug user or drug addict without any other showing of criminal activity. *See, e.g., Robinson v. California*, 370 U.S. 660, 667 (1962) (overruling California law that a defendant may be found guilty for being a drug addict without any proof that defendant used drugs within the state or participated in any anti-social behavior). The Court held that the California statute "inflict[ed] a cruel and unusual punishment in violation of the Fourteenth Amendment." *Id.*

135. *See, e.g., Linda A. Teplin et al., The Prevalence of Psychiatric Disorder Among Incarcerated Women*, 53 ARCHIVES GEN. PSYCHIATRY 505, 505 (1996) (Eighty per cent of female pretrial detainees interviewed had symptoms of lifetime psychiatric disorders, and

pert ability to predict violence in any case in which a defendant has a disorder (including substance abuse and mental retardation) that is studied by psychiatry.¹³⁶

However, psychiatric research does intersect with legal theory in its study of serious mental illnesses. These illnesses, including schizophrenia, bipolar disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder,¹³⁷ change the manner in which individuals behave by interfering with free will.¹³⁸ The delusions and hallucinations suffered by a schizophrenic, for example, alter that person's ability to distinguish reality from the images resulting from his illness.¹³⁹ While the individual may remain competent on one level—knows what day it is, the name of the current U.S. President, and can recite the roles of defense attorney, prosecutor, and judge—he still remains unaware of the falsity of his delusions,¹⁴⁰ and thus is likely to act upon those delusions as if they were reality. Such contradiction is demonstrated by the following conversation between the mentally ill mathematician and Nobel laureate, John Nash, and a long time friend, Harvard Professor George Mackey:

“How could you,” began Mackey, “how could you, a mathematician, a man devoted to reason and logical proof . . . how could you believe that extraterrestrials are sending you messages? How could you believe that you are being recruited by aliens from outer space to save the world? How could you . . .?”

Nash looked up at last and fixed Mackey with an unblinking stare as cool and dispassionate as that of any bird or snake. “Because,” Nash said slowly in his soft, reasonable southern drawl, as if talking to himself, “the ideas I had about supernatural beings came to me the same way that my mathematical ideas did. So I took them seriously.”¹⁴¹

70% were symptomatic within six months of the interview. The most common disorders were drug or alcohol abuse or dependence and post-traumatic stress disorder.).

136. See *infra* Part II.A.2 (discussing the DSM-IV, which classifies all disorders studied by psychiatry).

137. National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, NIMH Publication No. 01-4584, www.nimh.nih.gov/publicat/numbers.cfm (updated Jan. 1, 2001).

138. “For many individuals with schizophrenia who are not on medication, logical thinking is impossible.” TORREY, *supra* note 69, at 311. For example, “Serious mental illnesses (SMI) interfere with employment. An estimated 57 percent of adults with SMI were not employed in 1990 compared to 29 percent of the general population.” National Alliance for the Mentally Ill, <http://www.nami.org/helpline/factsandfigures.html> (Jan. 2001).

139. See TORREY, *supra* note 69, at 30-87.

140. “Despite cognitive deficits that affect complex information processing, many individuals with schizophrenia may appear superficially oriented and attentive, readily able to recognize familiar objects and persons, and able to communicate without obvious confusion—all aspects of mental capacity.” Davoli, *supra* note 70, at 1043 n.288 (quoting June R. Husted, *Insight in Severe Mental Illness: Implications for Treatment Decisions*, 27(1) J. AM. ACAD. PSYCHIATRY L. 33, 34 (1999)).

141. SYLVIA NASAR, *A BEAUTIFUL MIND* 11 (1998).

Thus, the psychotic delusions do not entirely replace reality. Instead, they complicate reality until the afflicted individual cannot differentiate reality from delusions.

Serious mental illnesses interfere with an individual's exercise of free will in a manner quite different from substance abuse or other, non-psychosis-inducing disorders.¹⁴² While addiction itself may strongly influence the decisions one makes, the addict is still making conscious choices and is aware of his actions, particularly *when sober*. The drug addict may feel compelled to steal in order to support his habit, but he is not compelled by his delusions. Rather, he is controlled by his desire for the substance. While he may lack the self-control to fight off his addiction, he does not suffer from delusions, such as his need to use narcotics or alcohol to save the world from aliens,¹⁴³ to keep cannibals from taking over the government,¹⁴⁴ or because the President needed him to prevent world hunger.¹⁴⁵ Yet those are exactly the type of beliefs held by seriously mentally ill individuals who become violent.

Applying psychiatric predictions of violence to capital murder cases is flawed because the analysis fails to acknowledge the fact that the capital murder defendant has not lost his free will. Individuals who have been convicted of capital murder have either been found both sane and competent, or have waived both the insanity and incompetence defenses prior to trial. Therefore, if they suffer from a serious mental illness, either it did not result in an acquittal or was not asserted by the defense.

A criminal defendant who is not suffering from delusions is exercising his free will—he determined to commit certain acts and intended the consequences of his acts. Expert testimony is not needed to explain to the jury that an individual has free will and may decide to kill again. Psychiatric testimony is not needed to explain to the jury that murderers are more likely to kill again than non-murderers. An expert in statistics can explain that to the jury.¹⁴⁶ Yet that is the substance of the psychiatrist's prediction of future dangerousness in cases where the defendant does not suffer from a serious mental illness.

In essence, the jury is given the impression that the psychiatrist has somehow looked inside the defendant's brain and found that future violence is ready to burst out at the first opportunity. In fact, the psychiatrist

142. Widiger & Troll, *supra* note 19, at 203-26.

143. NASAR, *supra* note 141, at 11; *see also id.* at 253-61.

144. United States v. Weston, 206 F.3d 9, 19 (D.C. Cir. 2000).

145. Mr. Head "came to believe that he would be 'the one' that would bring salvation or special benefit to the world, and 'find a way of helping everyone else in the world.'" Psychological Report, *supra* note 1, at 37.

146. Barefoot v. Estelle 363 U.S. 921-22 (1983) (Blackmun, J., dissenting).

The APA also concludes . . . as do researchers that have studied the issue that psychiatrists simply have no expertise in predicting long-term future dangerousness. A layman with access to relevant statistics can do at least as well and possibly better; psychiatric training is not relevant to the factors that validly can be employed to make such predictions, and psychiatrists consistently err on the side of overpredicting violence.

Id.

is either applying statistical evidence or guessing.¹⁴⁷ Speculation is not admissible in court, and¹⁴⁸ when a speculating witness has first paraded his credentials before the court and is qualified as an expert in an area that appears to include mind-reading,¹⁴⁹ his testimony is not only damaging but also diminishes the integrity of the criminal justice system. Since the defendant is not delusional as a result of mental illness, he can choose to kill again. The defendant is not a robot, but has the ability to exercise free will. No expert should be permitted to testify otherwise.

A psychiatrist's prediction of violence in the case of an individual *not* suffering from a serious mental illness has no greater weight or validity than a layperson's opinion. Simply because psychiatrists have an opinion on the defendant's future behavior should not automatically result in the admissibility of that opinion. As discussed below, the testimony should be related to the expert's area of expertise and be based in sound scientific evidence.¹⁵⁰

In contrast, only individuals suffering from a mental illness are subject to civil commitment.¹⁵¹ A competent attorney representing the respondent in a civil commitment hearing would certainly question the accuracy of the diagnosis of mental illness. Relevant areas of inquiry into the quality of the examination would include: (1) whether the medical history was reviewed;¹⁵² (2) whether a physical examination was performed;¹⁵³ (3) whether a social history was gathered;¹⁵⁴ and (4) whether the patient actually exhibits enough of the symptoms of the alleged illness to justify the diagnosis.¹⁵⁵

Once the petitioner has met his burden of proof¹⁵⁶ regarding the accuracy of the diagnosis, the court should consider its consideration on the

147. See *id.* at 920-22.

148. "Witnesses may not be asked to speculate or guess." LUBET, *supra* note 59, at 306.

149. Dr. Grigson had "testified against 124 murderers, and impressionable juries have sentenced 115 of them to death. After years of examining killers, Dr. Death believes that most are not mentally disordered at all, but instead match the diagnosis: 'mean son of a bitch.' His specialty is predicting which of them is likely to kill again . . ." Ann Jones, *In the Darkest Corners*, WASH. POST BOOK REV., Jan. 27, 1991, at X7 (reviewing RON ROSENBAUM, *TRAVELS WITH DR. DEATH AND OTHER UNUSUAL INVESTIGATIONS* (1991)).

150. See *infra* Part III.

151. Civil commitment is primarily a state level function, and the states have various definitions for what constitutes mental illness. See Davoli, *supra* note 70, at 1033 n.248 (providing a survey of various terms used by state codes to define mental illness).

152. See *infra* Part II.A.1.

153. See *infra* Part II.A.1.

154. See *infra* Part II.A.1.

155. See *infra* Part II.A.2.

156. The burden of proof is "clear and convincing." *Addington v. Texas*, 441 U.S. 418 (1979). In *Addington*, the United States Supreme Court decided upon the clear and convincing standard because of its mistrust of psychiatric diagnosis:

At one time or another every person exhibits some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable. Obviously, such behavior is no basis for compelled treatment and surely none for confinement. However, there is the possible risk that a factfinder might decide to commit an individual based solely on a few isolated instances of unusual conduct. Loss of liberty calls for a showing that

likelihood of future violence as a result of the individual's mental illness, not as a result of reasonableness or feasibility of his threats or behavior. The flawed premise underlying the marginalization of psychiatric evidence in civil commitment cases is that the mentally ill individual's free will is *not* affected by psychosis, and that the patient will *not* act in accordance with his delusions.

II. SCIENTIFIC STUDIES OF PSYCHIATRY AND FUTURE DANGEROUSNESS

Scientific research has examined whether diagnoses of mental illness are reliable and whether or not psychiatrists are able to accurately predict who will become violent in the future. Research into the validity and reliability of psychiatric diagnosis reveals that certain diseases are more easily and uniformly diagnosed than others.¹⁵⁷ Research also reveals when and under what circumstances a psychiatrist can make reasonably reliable predictions about a patient's future.¹⁵⁸

A. RELIABILITY OF PSYCHIATRIC DIAGNOSIS

Great faith is placed in medical diagnoses on a daily basis. Individuals receive treatment for high blood pressure, heart disease, diabetes, and influenza without much skepticism. If there is concern about the accuracy of a diagnosis or the advisability of a prescribed treatment, a "second opinion" might be sought from another doctor with expertise in the field. The resulting second opinion typically results in identical diagnoses with very similar treatment plans.¹⁵⁹

Both popular media and court opinions, however, consistently reflect a belief that psychiatry is an inexact pseudo-science.¹⁶⁰ Contrary to such depictions, there is great integrity in the diagnosis of mental illness. The validity of the diagnosis that an individual is suffering from a major mental illness such as schizophrenia depends upon the thoroughness of the examination, similar to the validity of any other diagnosis. Certainly, it is possible to misdiagnose a mental illness because of poor medical

the individual suffers from something more serious than is demonstrated by idiosyncratic behavior.

Id. at 426-27. This quote reflects the same type of concern reflected in other civil commitment hearings described in this article. See *supra* Part I.B.

157. HAROLD L. KAPLAN & BENJAMIN J. SADOCK, SYNOPSIS OF PSYCHIATRY: BEHAVIORAL SCIENCES/CLINICAL PSYCHIATRY 1 (1998) ("Clinical experience has shown that, on the basis of such assessment, it is possible, with respect to certain diagnostic entities, to predict patients' responses to therapy with a fair degree of accuracy. For example, the acute symptoms of many patients with schizophrenia improve with appropriate antipsychotic medication . . .").

158. See *infra* Part II.B.

159. See, e.g., University of Minnesota Cancer Center Getting a Second Opinion, <http://www.cancer.umn.edu/page/patients/opinion.html> (Dec. 19, 2002) ("In most cases, second opinions support the recommendation of the first physician."); Yale Medical Group, http://info.med.yale.edu/yfp/sec_opin.html (Apr. 11, 2001) ("Getting a second opinion most often results in the second physician affirming what the first physician initially recommended.").

160. Davoli, *supra* note 70.

practice, but it is just as easy to misdiagnose a physical ailment such as diabetes. Both types of examinations must follow accepted medical practice to ensure their validity.

While many scholars have lamented that psychiatry is too inexact a science to satisfy admissibility requirements,¹⁶¹ the majority of their data dates from some time ago.¹⁶² Dated material fails to take into account the dramatic advances made in the study of mental illness and often reflects obsolete or incorrect theories about psychiatry.¹⁶³ Psychiatry has refined its diagnosis and treatment methods over the past fifty years,¹⁶⁴ however, with significant advances and discoveries made in the last ten years. Thus, the present day reliability of psychiatric diagnosis is much greater than it has been in the past.

1. Complete Psychiatric Examination

An accurate psychiatric diagnosis requires a complete examination, also referred to as a diagnostic workup. The workup must include a history and mental status examination, whereby the doctor inquires about visual hallucinations, headaches, recent head injuries, and the use of street drugs and medications.¹⁶⁵ A review of the patient's prior medical history is important. A physical examination is also necessary to eliminate the possibility that a physical ailment, such as viral encephalitis,¹⁶⁶ is causing the symptoms of mental illness. A neurological examination

161. Christopher Slobogin, *Doubts About Daubert: Psychiatric Anecdotes as a Case Study*, 57 WASH. & LEE L. REV. 919, 921 (2000) ("Unfortunately, the validity of psychiatric opinion is hard to gauge. A diagnosis is merely a hypothetical construct; it lacks clear objective referents."); Michael H. Gottesman, *Admissibility of Expert Testimony After Daubert: The "Prestige" Factor*, 43 EMORY L.J. 867, 875 (1994) ("Are psychiatrists' assessments of the mental capacity of a defendant at the time of the crime 'testable' or 'falsifiable' or 'refutable'? Plainly not. Can we determine the 'error rate' or psychiatric opinion, or utilize standards to control the technique's operation? Again, plainly not.").

162. For example, Professor Slobogin relied on a source that was twenty-two years old. Slobogin, *supra* note 161, at 921 ("Unlike much physical disorder that often can be verified by various tests that measure pathology (whether or not cause of symptom, syndrome, or condition is known), there is no objective, empirical referent of *mental* disorder other than crazy behavior itself." (citing Stephen Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 607 (1978))).

163. Professor Slobogin also relies on Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 721 (1974), which states that "each school of psychiatry has a different view of what mental illness is, how it is caused, and how it should be treated," and Paul Lazare, *Hidden Conceptual Models in Clinical Psychiatry*, 288 NEW ENG. J. MED. 345 (1973), which identifies four models of behavioral science: medical—in which mental state is caused by biological conditions; psychologic—which interprets personality as the result of patterns established in youth; behavioral—which sees behavior and accompanying thoughts as the result of specific aversive or reinforcing events; and social—which focuses on relationships with family, peers and institutions as major influences on mental condition. Slobogin, *supra* note 161, at 919.

164. Davoli, *supra* note 70.

165. TORREY, *supra* note 69, at 180.

166. "There are several diseases of the body that can produce symptoms similar to schizophrenia . . . It has been known for many years that viral encephalitis can produce schizophrenia-like symptoms." *Id.* at 110. "Although psychiatrists do not perform routine physical examinations on their patients, they should be able to distinguish physical diseases

should "help identify patients with other brain diseases, such as brain tumors or Huntington's disease, who may initially present with schizophrenia-like symptoms."¹⁶⁷ Basic laboratory work should include a complete blood count, blood chemical screen, and urinalysis.¹⁶⁸ Psychological tests will also assist the doctor in reaching an accurate diagnosis.¹⁶⁹ Other diagnostic tests performed may include magnetic resonance imaging (MRI) scans, computerized tomography (CT) scans, and lumbar punctures.¹⁷⁰ The thoroughness of the workup produces a diagnosis with a high level of accuracy.

The reliability of a diagnosis of mental illness is supported by scientific research. Studies have been performed that prove both the existence of mental illness and the ability of psychiatrists to consistently diagnosis the same symptoms and reach identical results. "It no longer seems necessary to apologize for poor diagnostic reliability in psychiatry. Carefully constructed interview schedules and lists of diagnostic criteria, together with rigorous training of raters, have caused a quantum jump in the magnitude of psychiatric reliability."¹⁷¹ Psychiatric diagnoses currently have similar levels of reliability to other medical fields such as radiologists' interpretations of mammograms, and the assessment of spasticity in patients with spinal cord injury.¹⁷²

Psychiatric examinations also recognize that some patients may be motivated to fake an illness or trick the evaluator. Such behavior is called malingering:

Malingers have an obvious, recognizable environmental goal in producing signs and symptoms. They may seek hospitalization to secure financial compensation, evade the police, avoid work, or merely obtain free bed and board for the night, but they always have some apparent end for their behavior. Moreover, these patients can usually stop producing their signs and symptoms when they are no longer considered profitable or when the risk becomes too great.¹⁷³

that mimic psychiatric disorders and vice versa." KAPLAN & SADOCK, *supra* note 157, at 268.

167. *Id.* at 180.

168. *Id.*

169. DAVID L. WODRICH & SALLY A. KUSH, CHILDREN'S PSYCHOLOGICAL TESTING: A GUIDE FOR NONPSYCHOLOGISTS 15 (1990).

[Psychological tests focus on observable, objective, quantifiable behavior. They strive to produce results that can be subjected to scrutiny by peers. Research on psychological testing is reported in highly technical journals in a format conducive to criticism, investigation, and replication. The principals and procedures associated with testing are embedded in a carefully thought-out system called psychometric theory . . . Research often combines observation, logic, and powerful statistical methods, the signs of a mature science.

Id.

170. TORREY, *supra* note 69, at 181.

171. William M. Grove et al., *Reliability Studies of Psychiatric Diagnosis*, 38 ARCHIVES OF GEN. PSYCHIATRY 408 (1981).

172. Roberta F. White et al., *Interrater Reliability of Neuropsychological Diagnoses: A Department of Veterans Affairs Cooperative Study*, 8 J. OF THE INT'L NEUROPSYCHOLOGICAL SOC'Y 555-65 (2002).

173. KAPLAN & SADOCK, *supra* note 157, at 658.

The DSM-IV recognizes malingering and lists specific concerns that strongly indicate a patient might be faking his condition.¹⁷⁴ Psychological tests specifically control to eliminate the ability of the patient to feign symptoms of mental illness.

Additionally, while experts may routinely answer hypothetical questions in their testimony, such evidence should not be admissible unless the expert's profession has adopted that method. Similar to every area of medicine, psychiatrists do not typically diagnose without first examining the patient and reviewing all the relevant medical records. While there may be some limited exceptions to this rule,¹⁷⁵ answering hypothetical questions is not the accepted manner for psychiatrists to diagnosis patients.

2. *The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition*

The American Psychiatric Association publishes the *Diagnostic and Statistical Manual of Mental Disorders*.¹⁷⁶ This exhaustive manual categorizes types of psychiatric illness and lists the diagnostic criteria for classifying a patient's illness. The specific diagnostic "criteria include a list of features that must be present for the diagnosis to be made. Such criteria increase the reliability of clinicians' process of diagnosis."¹⁷⁷ The DSM-IV provides clarity and consistent standards for the diagnosis of mental illness.

With the DSM-IV as the foundation, a variety of different studies have been performed to assess and improve the accuracy of psychiatric diagnosis. "To improve diagnostic accuracy, several structured clinical inter-

174. DSM-IV, *supra* note 16, at 683.

The essential feature of Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, Malingering may represent adaptive behavior—for example, feigning illness while a captive of the enemy during wartime.

Malingering should be strongly suspected if any combination of the following is noted:

1. Medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination)
2. Marked discrepancy between the person's claimed stress or disability and the objective findings
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
4. The presence of Antisocial Personality Disorder.

Id.

175. "Diagnosis without Examination: Is it ethical to offer a diagnosis based only upon review of records to determine, for insurance purposes, if suicide was the result of illness? Yes. Is it ethical for a supervising psychiatrist to sign a diagnosis on an insurance form for services provided by a supervisee when the psychiatrist has not examined the patient? Yes, if the psychiatrist ensures that proper care is given and the insurance form clearly indicates the role of supervisor and supervisee." KAPLAN & SADOCK, *supra* note 157, at 1324.

176. DSM-IV, *supra* note 16.

177. KAPLAN & SADOCK, *supra* note 157, at 287.

views, such as the Structured Clinical Interview for DSM-III-R¹⁷⁸ (SCID) and the National Institute of Mental Health Diagnostic Interview Schedule (DIS), have been created and tested.”¹⁷⁹ Reviews of these methods reveal that structured interviews result in more accurate diagnoses “because they facilitate symptom reporting while systematically probing symptoms and behaviors that clinicians may overlook, hence reducing variability.”¹⁸⁰

Yet, an individual does not suffer from a mental illness merely because he meets the criteria for a diagnosis in the DSM-IV. The DSM-IV lists all diagnosable conditions, some that are completely irrelevant to legal issues. In fact, the DSM-IV warns that “in most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes”¹⁸¹ of the various conditions defined in law. Thus, courts need to critically assess the relevance of an individual’s diagnosis when determining whether to admit psychiatric testimony.

B. RELIABILITY OF PREDICTIONS OF FUTURE DANGEROUSNESS

Legal scholars are beginning to recognize that psychiatric evidence can be of some value in predicting violence, but only in those cases where the patient suffers from a serious mental illness and meets other criteria. There are two types of predictions. One is based solely on the clinical assessment of the patient. The other involves applying statistics to the relevant factors. “In the past several years, the field of ‘violence risk assessment’ has seen a dramatic shift away from studies attempting to validate the accuracy of clinical predictions, and toward studies attempting to isolate specific risk factors that are actuarially (meaning statistically) associated with violence.”¹⁸²

Recent studies have “demonstrated that clinicians may be fairly accurate in predicting dangerousness . . . when their prediction concerns an inpatient psychiatric population over a relatively short period of time . . .

178. DSM-III-R is the precursor to the DSM-IV:

DSM-III-R, published in 1987, is a third generation revision of the original DSM, that was developed in 1952 by the American Psychiatric Association. DSM-II was published in 1968, followed by DSM-III in 1980. The manual is the primary classification system for psychiatric disturbances occurring in children and adults . . . It is widely used by everyone connected with psychiatry, from trainers and prospective clinicians to insurance companies to hospital staff workers.

WODRICH & KUSH, *supra* note 169, at 161.

179. Monica Ramirez Basco et al., *Methods to Improve Diagnostic Accuracy in a Community Mental Health Setting*, 157 AM. J. PSYCHIATRY 1599-605 (2000).

180. *Id.* at 1599.

181. *Id.*

182. John Monahan, *Violence Risk Assessment: Scientific Validity and Evidentiary Admissibility*, 57 WASH. & LEE L. REV. 901, 905-06 (2000) (referring to Helena Chmura Kraemer et al., *Coming to Terms with the Terms of Risk*, 54 ARCHIVES OF GEN. PSYCHIATRY 337 (1997)). “To say that a variable is a ‘risk factor’ for violence means only two things: (1) the variables correlates with the outcome (in this case, violence), and (2) the variable precedes the outcome. To call a variable a ‘risk factor’ does not imply that its relationship to the outcome is in any sense ‘casual.’” *Id.* at 905 n.27.

This research does not, however, support the idea that clinicians are accurate in predicting the long-term dangerousness of a criminal defendant.”¹⁸³ Psychiatric evidence is most relevant and reliable when the individual is seriously mentally ill with an affliction that results in delusions.¹⁸⁴

The factors consistent with the profile of someone with mental illness who is imminently dangerous include the following: (1) suffers from a serious mental illness, (2) non-compliance with treatment and medication, (3) use of narcotics or alcohol, (4) previous violence, (5) currently psychotic, and (6) suffers from hallucinations and delusions. Predictions tend to be more reliable when they concern the immediate future.¹⁸⁵ In addition, the state of psychosis is not constant. Rather, it waxes and wanes with the illness. When symptoms are in a state of flux, predictions are more accurate when made at the time of the psychosis concerning the behavior likely to occur during that time period.

1. *Serious Mental Illness*

Predictions of future violence are more accurate when they concern an individual who suffers from a major mental illness. “[S]erious mental disorder by itself is quite significantly associated with violence.”¹⁸⁶ Typically, such illnesses include delusions or hallucinations. “Hallucinations occur in a heterogeneous group of psychiatric disorders, particularly schizophrenia, major mood disorders (e.g., bipolar disorder and major depression), personality disorders, and dissociative disorders.”¹⁸⁷

Research has shown that “(1) the prevalence of violence is over five times higher among people who meet criteria for a DSM-III Axis I diagnosis . . . than among people who are not diagnosable . . . ; (2) the prevalence of violence among persons who meet criteria for a diagnosis of schizophrenia, major depression, or mania/bi-polar disorder is remarkably similar.”¹⁸⁸ Evidence that serious mental illness correlates with vio-

183. Daniel A. Krauss & Bruce D. Sales, *The Effects of Clinical and Scientific Expert Testimony on Juror Decision Making in Capital Sentencing*, 7 PSYCHOL. PUB. POL’Y & L. 267, 310 n.2 (2001) (referring to Dale E. McNiel et al., *The Relationship Between Confidence and Accuracy in Clinical Assessment of Psychiatric Patients’ Potential for Violence*, 22 LAW & HUMAN BEHAVIOR 655-71 (1998)).

184. See generally Pamela J. Taylor et al., *Delusions and Violence*, in VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT (John Monahan & Henry J. Steadman eds., 1994).

185. “Patients were at highest risk for involvement in violence in the first 20 weeks after hospital discharge.” JOHN MONAHAN ET AL., *RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE* 34 (2001).

186. Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, in VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 119 (John Monahan & Henry J. Steadman eds., 1994).

187. McNiel, *supra* note 52, at 184.

188. John Monahan, *Scientific Status*, in FAIGMAN ET AL., *supra* note 14, at 94. In the DSM-IV, Axis I Clinical Disorders are the following: Delirium, Dementia, and Amnesia and Other Cognitive Disorders; Mental Disorders Due to a General Medical Condition Substance-Related Disorders Schizophrenia and Other Psychotic Disorders; Mood Disorders; Anxiety Disorders; Somatoform Disorders; Factitious Disorders; Dissociative Disor-

lence supports the argument that psychosis interferes with an afflicted individuals' ability to exercise free will.

2. *Non-Compliance with Treatment and Medication*

The second risk factor for violence is that the afflicted individual does not routinely take prescription medications or attend psychiatric treatment sessions. "The common denominators of [individuals with schizophrenia] who are assaultive and violent are abuse of alcohol or drugs and/or non-compliance with antipsychotic medication."¹⁸⁹ Medication non-compliance is a significant risk factor for violence primarily because without the antipsychotic medication, the individual becomes delusional.

Several studies have confirmed that non-compliance with medication is a major risk factor for violence. For example, one study in Virginia demonstrated that patients who refused their medication "were more likely to be assaultive, were more likely to require seclusion and restraint, and had longer hospitalizations."¹⁹⁰ Another study found that "[s]eventy-one percent of the violent patients . . . had problems with medication compliance, compared with only 17 percent of those without hostile behaviors."¹⁹¹ Failure to comply with anti-psychotic medication may stem from several causes, including lack of insight¹⁹² and dislike of side-effects,¹⁹³ but that failure greatly increases the risk that the mentally ill individual will become violent.¹⁹⁴

3. *Narcotics and Alcohol*

The third risk factor occurs when an individual has a dual diagnosis, which means being diagnosed as both mentally ill and a substance abuser. "Dually diagnosed patients demonstrate increased rates of hospitalization, utilization of acute care services, housing instability and homelessness, violent and criminal behavior, and suicidal behavior."¹⁹⁵ Although substance abuse alone increases an individual's risk of becoming violent, "respondents with dual diagnoses had a much greater risk of violence

ders; Sexual and Gender Identify Disorders; Eating Disorders; Sleep Disorders; Impulse-Control Disorders; Not Elsewhere Classified; Adjustment Disorders; and Other Conditions That May Be a Focus of Clinical Attention. DSM-IV, *supra* note 16, at 26.

189. TORREY, *supra* note 69, at 307.

190. John A. Kasper et al., *Prospective Study of Patients' Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure*, 154 AM. J. OF PSYCHIATRY 483-89 (1997).

191. Stephen J. Bartels et al., *Characteristic Hostility in Schizophrenic Outpatients*, 17 SCHIZOPHRENIA 163-66 (1991).

192. "Decreased awareness of illness is officially referred to in neurological terms as anosognosia The lack of awareness of illness is the largest single cause of the need for involuntary hospitalization and medication." TORREY, *supra* note 69, at 79-80.

193. "A third major reason for medication noncompliance among individuals with schizophrenia is the side effect of the medication." *Id.* at 296.

194. Fred Osher & Lial Kofoed, *Treatment of Patients with Psychiatric and Psychoactive Substance Abuse Disorders*, 40 HOSP. & COMMUNITY PSYCHIATRY 1025, 1030 (1989).

195. *Id.*

than those with mental disorder alone.”¹⁹⁶

Research has demonstrated that “[m]entally disordered individuals with substance abuse comorbidity are significantly more likely to be violent than those with mental disorder alone.”¹⁹⁷ One study concluded that “[s]ubstance abuse was diagnosed as co-occurring with mental disorders in 40-50% of cases in the patient group,” and that “[t]he presence of substance abuse increased the frequency of both serious violence and other aggressive acts.”¹⁹⁸

4. *Prior Violence*

Individuals with a prior history of violence are more likely to become violent in the future.¹⁹⁹ “Violent behavior results from a complex interaction among a variety of social, clinical, personality, and environmental factors whose relative importance varies across situations and time.”²⁰⁰ Yet no matter what the cause, previous violence is a clear risk factor for future violence.

5. *Hallucinations and Delusions*

“Research . . . has identified a positive relationship between hallucinations and violent behavior.”²⁰¹ The type of hallucinations suffered by the individual—particularly command hallucinations—and occurrence during the acute period of the illness contributes to the likelihood of violent behavior. “Command hallucinations are auditory hallucinations that instruct the patient to act in a certain manner. The actions that command hallucinations order the patient to perform range from the insignificant, such as making facial grimaces, to those as serious as suicidal or homicidal acts.”²⁰² The timing of the hallucination is likewise important, since “[m]ost studies documenting associations between hallucinations and violence have evaluated patients during acute episodes of illness, such as the period just before or after hospital admission.”²⁰³

Other variables also affect the likelihood of whether or not the hallucinating individual will become violent. When an individual suffers from an untreated mental illness, and has been responding to hallucinations, there is a high likelihood that he will continue to behave in the same manner. In fact, “if a patient has a history of behaving violently in response to hallucinations, the risk of assault is obviously higher than would

196. Swanson, *supra* note 186, at 113.

197. *Id.* at 119.

198. Kirk Heilbrun & Gretchen Witte, *The MacArthur Risk Assessment Study: Implications for Practice, Research, and Policy*, 82 MARQ. L. REV. 733, 747-48 (1999).

199. “Clearly, prior violence and criminality are strongly associated with the postdicharge violent behavior of psychiatric patients.” MONAHAN ET AL., *supra* note 185, 46-47.

200. Widiger & Troll, *supra* note 19, at 216.

201. McNiel, *supra* note 52, at 194.

202. Keith Hersch & Randy Borum, *Command Hallucinations, Compliance, and Risk Assessment*, 26 J. AM. ACAD. PSYCHIATRY L. 353 (1998).

203. McNiel, *supra* note 52, at 195.

be the case with only the knowledge that the patient is hallucinating.”²⁰⁴ Additionally, “[e]ven among people who had never been formally treated for mental disorder, actively experiencing psychotic symptoms was associated with the commission of violent acts.”²⁰⁵ Thus, the significance of a prior violent history increases when the individual’s previous violence has occurred simultaneously with his suffering from hallucinations.

In addition, the location of the individual at the time of his hallucinations may affect whether he will become violent. Several studies have concluded that “patients with paranoid schizophrenia are more likely to be violent outside the hospital setting, but are not especially violent in hospital settings following an initial period of stabilization.”²⁰⁶ Since even individuals who were not previously hospitalized become violent when psychotic,²⁰⁷ involuntary hospitalization may not only offer safe haven to the afflicted, but may also have an immediate, positive affect on the individual’s behavior.

Delusions may affect the likelihood that an individual will act violently while hallucinating. “Delusions . . . are erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, or grandiose).”²⁰⁸ An example of an individual suffering from delusions who then acts violently because of a hallucination would be if Mr. Patient has the delusion that he is all-powerful and must kill anyone who defies him, and then has a hallucination that the President is defying him. Mr. Patient would then feel obligated to kill the President. “[I]t appears that the presence of a delusional belief consistent with the content of the hallucination increases the likelihood of compliance [P]rior research has shown the presence of delusions related to perceived threat or an overriding of one’s internal controls is associated with increased risk for violent behavior.”²⁰⁹

Research clearly demonstrates that active hallucination increases the risk that a mentally ill individual will become violent. “The currently mentally disordered—those actively experiencing serious psychotic symptoms—are involved in violent behavior at rates several times those of nondisordered members of the general population.”²¹⁰ Such evidence demonstrates the importance of a clinical assessment in violence prediction.

204. *Id.*

205. John Monahan, *Scientific Status*, in FAIGMAN ET AL., *supra* note 14, at 95.

206. McNiel, *supra* note 52, at 195.

207. John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511, 517 (April 1992).

208. DSM-IV, *supra* note 16, at 275.

209. Hersh & Borom, *supra* note 202, at 357.

210. Monahan, *supra* note 207, at 517.

III. SOLUTION: REPLACE SOOTHSAYING WITH SCIENTIFIC INTEGRITY

In addressing the admissibility of psychiatric evidence, courts should acknowledge that the consequences faced by the individual subject to the death penalty are much more serious than those faced by the individual subject to civil commitment.²¹¹ While an inaccurate diagnosis or prediction of violence in civil commitment might result in deprivation of the individual's liberty, it is for a fixed period of time,²¹² in a therapeutic—not penal—setting,²¹³ with the additional oversight of psy-

211. While civil commitment may negatively affect an individual's quality of life in such ways as stigmatizing that individual, *see, e.g.*, OTTO F. WAHL, *MEDIA MADNESS: PUBLIC IMAGES OF MENTAL ILLNESS* (1995), an unfair death sentence is still immeasurably more serious than an unfair civil commitment.

212. REISNER & SLOBOGIN, *supra* note 129, at 740.

Although at one time commitment in many states was truly indeterminate, most states now require . . . that a review hearing be held after a certain period of involuntary treatment. Typically, a hearing similar in kind to the initial adjudicatory hearing must be held within six months of the previous commitment; other fairly common review periods are three months and a year.

Id.

213. The number of severely mentally ill individuals imprisoned now greatly exceeds the number in psychiatric hospitals. Yet, the penal setting is much more brutal for a mentally individual:

For most individuals with schizophrenia, the experience of being jailed varies from "unpleasant" to "a living hell." Being ridiculed by guards or other prisoners is the least problem; in some jails "mental cases" wear uniforms of a different color and so are readily identifiable Jails require prisoners to follow rules, but following rules assumes that your brain is thinking logically. For many individuals with schizophrenia who are not on medication, logical thinking is impossible. Such individuals commit bizarre acts that cause problems for everyone. In California, a newspaper reported that mentally ill inmates in one jail "try to escape by smearing themselves with their own feces and flushing themselves down the toilet."

TORREY, *supra* note 69, at 311.

One day last month Jesus Portelles, stripped naked and convinced that demons had entered his body, used the broken edge of a plastic spoon to carve open his stomach. By the time the guards could unlock his cell door and grab him, his guts were spilling out. But the demons stayed.

That same day Luis Nunez was freed from four-point restraints—which bound him by the wrists and ankles, spread-eagled on a bare metal slab—after a change in medication helped him to stop smashing his head against the wall until he bled. And he was better for a while. When I was there, he was on his feet and yelling "*Where are my shoes?!*" But last week he was back in full restraints.

As sick as they are, Portelles and Nunez are not in a psychiatric facility where they should be.

Instead, they are prisoners in the Miami-Dade County Jail, two of more than 325 men charged with felonies and even misdemeanors who are being heavily medicated and warehoused in small, cold, overcrowded and filthy cells in what has become the largest psychiatric facility in the state of Florida [They are held in] the maximum security section of the psych ward, where up to 40 inmates identified as acutely ill and extremely violent are held in 24-hour lockdown They are permitted no books, no pencil, not a stitch of clothing, nothing that could be fashioned into a weapon or a noose. Visitors are not allowed. The inmates are not taken out for exercise. They have no access to a telephone. . . .

chiatrists,²¹⁴ and typically with additional court hearings required for in-

The single bunk has no mattress or sheets. Food comes in Styrofoam boxes shoved through a slot in the steel door. Offered a shower three times a week, prisoners often refuse it. When the stench grows unbearable, guards pull uncooperative inmates out of their cells and slosh them down with a green garden hose.

It wasn't supposed to be this way. But with state hospitals closing, and few community-based health services available for mentally ill criminals considered a danger to themselves and others, three floors of the fifty-year-old jail at 1321 NW 13th St. now serve as the asylum of the new millennium. Thanks to psychotropic drugs that can sedate even the most disturbed prisoner, the jail isn't exactly bedlam. Outbursts of screaming and wailing, bouts of self-mutilation, and psychotic breakdowns where prisoners eat or throw their own feces are frequent but not constant. But even on the best of days, the jail's psych ward is a gloomy, forbidding madhouse . . .

"It's hell, it truly is," says forensic psychologist Merry Haber. "Medieval. If you saw this in any other country you'd call it a human rights abuse."

Even the jail's staff admits that conditions are horrible, especially for the one-fourth of the jail's 1750 inmates suffering from mental illness. "It's a shocking environment: old barbaric, archaic," sighs Joseph Poitier, the jail's chief psychiatrist for the past eight years. "Primarily we practice triage, and then it's management by medication. The jail environment is not conducive to traditional treatment. We do the best we can."

Arrested in December, Nunez several weeks ago was judged competent and allowed to plead guilty to misdemeanor assault, and sentenced to 364 days in county jail. So he's doing his time—in four point restraints.

Mike Clary, *The Snake Pit*, MIAMI NEW TIMES, July 11, 2002.

214. The United States Supreme Court endorsed this "gatekeeper" function of psychiatrists in juvenile cases:

As with most medical procedures, Georgia's are not totally free from risk of error in the sense that they give total or absolute assurance that every child admitted to a hospital has a mental illness optimally suitable for institutionalized treatment. But it bears repeating that "procedural due process rules are shaped by the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions."

Georgia's procedures are not "arbitrary" in the sense that a single physician or other professional has the "unbridled discretion" the District Court saw to commit a child to a regional hospital. To so find on this record would require us to assume that the physicians, psychologists, and mental health professionals who participate in the admission decision and who review each other's conclusions as to the continuing validity of the initial decision are either oblivious or indifferent to the child's welfare—or that they are incompetent. We note, however, the District Court found to the contrary; it was "impressed by the conscientious, dedicated state employed psychiatrists who, with the help of equally conscientious, dedicated state employed psychologists and social workers, faithfully care for the plaintiff children . . ."

This finding of the District Court also effectively rebuts the suggestion made in some of the briefs *amici* that hospital administrators may not actually be "neutral and detached" because of institutional pressure to admit a child who has no need for hospital care. That such a practice may take place in some institutions in some places affords no basis for a finding as to Georgia's program; the evidence in the record provides no support whatever for that charge against the staffs at any of the State's eight regional hospitals. Such cases, if they are found, can be dealt with individually; they do not lend themselves to class-action remedies.

We are satisfied that the voluminous record as a whole supports the conclusion that the admissions staffs of the hospitals have acted in a neutral and detached fashion in making medical judgments in the best interests of the children. The State, through its mental health programs, provides the authority for trained professionals to assist parents in examining, diagnosing, and

voluntary administration of medications²¹⁵ or other treatments.²¹⁶

In contrast, an inaccurate diagnosis or prediction of violence in a capital murder case results in the defendant being executed. With a death sentence, there is no fixed period of time after which the accuracy of the mental illness diagnosis or violence prediction will be reviewed.²¹⁷ While awaiting execution, the defendant remains in prison. If medical personnel ever treat the defendant again, they make no inquiry into the validity of the initial diagnosis to re-assess whether the defendant needs to be executed.²¹⁸ Appellate review concerns trial errors made by the judge.²¹⁹ An inquiry into the accuracy of the psychiatrist's diagnosis or prediction of violence never occurs once the defendant is sentenced to death.²²⁰

treating emotionally disturbed children. Through its hiring practices, it provides well-staffed and well-equipped hospitals and—as the District Court found—conscientious public employees to implement the State's beneficent purposes.

Parham v. J.R., 442 U.S. 584, 615-16 (1979) (citations omitted).

215. "[S]everal courts have now recognized a 'right to refuse' psychotropic medication for institutionalized populations, in the process constitutionalizing a version of the informed consent doctrine in that context. The precise scope of this right is still being fleshed out" REISNER & SLOBOGIN, *supra* note 129, at 848.

216. Two feared psychiatric treatments are electrocardio (ECT) and psychosurgery, commonly referred to as lobotomy. State legislatures tightly restrict the availability of these procedures, which vary from complete prohibition to requiring court orders. *See Davoli, supra* note 70, at 1040 n.282 (listing the availability of ECT and psychosurgery in various states).

217. "[M]ost of the errors caught in time are corrected not thanks to the system but in spite of the system—that is, in spite of the obstacles to re-investigating and reopening a case, to persuading a higher court to reconsider, and to securing executive intervention to halt the march to the execution chamber." RADELET ET AL., *supra* note 8, at 280.

In addition, although the Supreme Court bars the execution of a mentally incompetent defendant, *see infra* note 220, the burden of proof is generally on the defendant to raise the issue post-sentencing. For example, in Texas, a defendant must file a motion to the trial court, which retains jurisdiction over the issue of post-sentencing competency:

If a defendant is determined to have previously filed a motion under this article, and has previously been determined to be competent to be executed, the previous adjudication creates a presumption of competency and the defendant is not entitled to a hearing on the subsequent motion filed under this article, unless the defendant makes a prima facie showing of a substantial change in circumstances sufficient to raise a significant question as to the defendant's competency to be executed at the time of filing the subsequent motion under this article.

TEX. CODE CRIM. PROC. ANN. art. 46.04 (Vernon 2002).

218. Of course, a competent psychiatrist may diagnose the convicted murderer with a different illness than was identified in trial testimony. But there is no subsequent review to determine the accuracy of the trial diagnosis, and nothing is done if subsequent examinations reveal that the defendant was not mentally ill.

219. NINA RIVKIND & STEVEN F. SHATZ, *CASES AND MATERIALS ON THE DEATH PENALTY* 561 (2001).

The scope and rules for direct review are determined by each jurisdiction, but such review generally is limited to issues arising from the record of the trial proceedings. Absent specific provisions permitting appellate courts to take evidence, issues on direct review cannot be based on factual information that is not included as evidence in the official transcripts of the trial.

Id.

220. The only reconsideration of the defendant's psychiatric illness occurs if he asserts that he is too insane to be executed. *See, e.g., Ford v. Wainwright*, 477 U.S. 399 (1986) (reversing denial of habeas corpus relief where Eighth Amendment prohibited execution

Thus, the risks of an inaccurate diagnosis and prediction of violence in capital murder cases are immense since an execution is irreversible, while the risks associated with an inaccurate diagnosis and prediction of violence in civil commitment cases are minimal. Commitment is not a permanent condition, and requires on-going judicial approval for extending hospitalization or outpatient treatment. Yet the courts tend to rely on psychiatric predictions most when the risks of misdiagnoses are greatest. The Supreme Court has sanctioned and protected the testimony of the psychiatrist in capital murder cases²²¹ where the risk of error is high and the results are irreversible. However, the Supreme Court is silent, and lower court rulings reflect a suspicion of psychiatry in civil commitment cases where the risk of error is much lower and the result is extremely limited.²²² Courts could do a better job of assessing the admissibility of predictions of future dangerousness if they incorporate the analysis inherent in the Federal Rule of Evidence for admission of expert testimony.²²³

A. *DAUBERT v. MERRELL DOW PHARMACEUTICALS, INC.*

A federal evidentiary test for admissibility of evidence does exist. In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,²²⁴ the United States Supreme Court reviewed the admissibility of scientific evidence in a federal trial. The *Daubert* plaintiffs sued Merrell Dow claiming that the anti-nausea drug it produced caused them serious birth defects. The district court granted Merrell Dow's motion for summary judgment by ruling that the plaintiff's experts' testimony was inadmissible. Pursuant to the standard expressed in *Frye v. United States*,²²⁵ the district court reasoned that scientific evidence is admissible "only if the principle upon which it is based is 'sufficiently established to have general acceptance in the field to which it belongs.'"²²⁶ The United States Court of Appeals for the Ninth Circuit affirmed.²²⁷

of the insane and where petitioner had been denied factfinding procedure adequate to afford full and fair hearing on issue of competence to be executed). There is never a reconsideration of whether or not he is likely to be dangerous in the future.

221. See *infra* Part II.A-B.

222. See discussion *supra* Part I.B.

223. LUBET, *supra* note 59, at 216.

Rule 702 of the Federal Rules of Evidence provides that expert opinions are admissible where the expert's "scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue." Thus, there are two threshold questions: (1) Does the witness possess sufficient scientific, technical, or other specialized knowledge?, and (2) Will that knowledge be helpful to the trier of fact?

Id.

224. 509 U.S. 579 (1993).

225. 293 F. 1013 (D.C. Cir. 1923) (holding that the trial court did not err when it refused to allow expert testimony as to the results of a systolic blood pressure deception test taken by appellant because the test had not yet received the required standing and scientific recognition from psychological and physiological authorities).

226. *Daubert*, 509 U.S. at 583 (quoting *United States v. Klingus*, 571 F.2d 508, 510 (9th Cir. 1978)).

227. *Daubert v. Merrell Dow Pharm., Inc.*, 951 F.2d 1128 (9th Cir. 1991).

The Supreme Court first determined that the controlling law in this area is no longer the traditional test expressed in *Frye*.²²⁸ The Court articulated that the Federal Rules of Evidence have displaced the *Frye* test, and have thus removed the requirement that the "thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs."²²⁹ The Court further stated that the federal rules do not incorporate the "general acceptance" standard of *Frye*.²³⁰

Given the Rules' permissive backdrop and their inclusion of a specific rule on expert testimony that does not mention "general acceptance," the assertion that the Rules somehow assimilated *Frye* is unconvincing. *Frye* made 'general acceptance' the exclusive test for admitting expert scientific testimony. That austere standard, absent from, and incompatible with, the Federal Rules of Evidence, should not be applied in federal trials.²³¹

The Court then held that "under the [Federal] Rules, the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable."²³² The relevance standard reflects the traditional rule that only testimony and other evidence relevant to the issues in a case are admissible.²³³

The second prong of *Daubert*'s admissibility test requires that scientific evidence must be reliable to be admissible. In order for expert testimony "to qualify as 'scientific knowledge,' an inference of assertion must be derived by the scientific method. Proposed testimony must be supported by appropriate validation—i.e., 'good grounds,' based on what is known. In short, the requirement that an expert's testimony pertain to 'scientific knowledge' established a standard of evidentiary reliability."²³⁴

The Court elaborated on its decision by making additional comments to guide the lower courts. First, the lower courts should determine whether the scientific theory or technique "can be (and has been) tested. 'Scientific Methodology today is based on generating hypotheses and testing them to see if they can be falsified; indeed, this methodology is what distinguishes science from other fields of human inquiry.'"²³⁵ Second, the lower court should inquire into "whether the theory or technique has been subjected to peer review and publication."²³⁶ While a

228. *Frye*, 293 F. at 1013.

229. *Daubert*, 509 U.S. at 586 (quoting *Frye*, 293 F. at 101-14).

230. *Id.* at 588-89.

231. *Id.* at 589.

232. *Id.*

233. "Relevance defines the relationship between the proffered evidence and some fact . . . at issue in the case. Evidence will not be admitted simply because it is interesting or imaginative. Rather, it must be shown to be probative . . . that it makes some disputed fact either more or less likely." LUBET, *supra* note 59, at 312.

234. *Daubert*, 509 U.S. at 590.

235. *Id.* at 593 (quoting CHARLES R. GREEN & ERIC D. NESSON, PROBLEMS, CASES, AND MATERIALS ON EVIDENCE 645 (1983)).

236. *Id.*

lack of peer review is not an absolute bar to admissibility of evidence, submission to the scrutiny of the scientific community is a component of 'good science,' in part because it increases the likelihood that substantive flaws in methodology will be detected."²³⁷

The Court further suggested that "in the case of a particular scientific technique, the court ordinarily should consider the known or potential rate of error . . . and the existence and maintenance of standards controlling the technique's operation."²³⁸ The Court also left room in these considerations for the concept of "general acceptance" being considered in the admissibility standard, just not controlling of it. "Widespread acceptance can be an important factor in ruling particular evidence admissible, and 'a known technique which has been able to attract only minimal support within the community' may properly be viewed with skepticism."²³⁹ Thus, these guidelines address threshold issues that courts should review prior to ruling on the admissibility of the expert testimony.

B. THE APPLICATION OF *DAUBERT* TO PSYCHIATRY

Applying the *Daubert* admissibility test to psychiatric evidence reveals that such testimony is relevant and reliable in some contexts, but not in others. Although this seems contradictory, every science has limitations and thus can provide reliable and relevant guidance in some areas, but not others. For example, a toxicology test can tell within a reasonable degree of scientific certainty whether a "fatal amount" of a drug was administered, but it usually cannot answer the specific question of exactly how many pills or doses of that drug an individual consumed.²⁴⁰ Another example is deoxyribonucleic acid (DNA) evidence. While some types of DNA testing can positively match genetic material with a particular suspect,²⁴¹ other DNA tests do not have that ability.²⁴² Thus, the reliability

237. *Id.*

238. *Id.* at 594.

239. *Id.* (citation omitted) (quoting *United States v. Downing*, 753 F.2d 1224, 1238 (3d Cir. 1985)).

240. For example, a fatal dose depends on the drug metabolism that varies from individuals and is influenced by age, weight, health and other variables.

241. Nuclear or STR DNA fingerprints can identify any individual (or identical twin) on the planet, assuming you have a database that includes the individual's nuclear STR DNA fingerprint (or you have a suspect to test that has the identical nuclear STR DNA fingerprint). Most scientists accept a "13 locus STR profile" as identity. Phone Interview with Dr. Keith McKenney, Associate Professor, George Mason University (May 1, 2003). Y chromosome STR DNA fingerprints are used when nuclear STR DNA fingerprints are mixed, as with a rape victim with multiple suspects, or the donor is not available, but living direct paternal descendents are known. Like mito typing, Y STRs are shared by all paternal relatives and so the statistical arguments on frequency of Y STR types is required to assist in evaluating a DNA "match." Fortunately, like mito typing, Y STRs are used much less frequently than nuclear (multi-locus) STR typing. *Id.*

242. Mitochondrial DNA is used when the nuclear STR DNA fingerprint fails and the case is important (mitochondrial DNA costs 10-20X more). Mito DNA is good for exclusions, but an inclusion is not identity. Mito DNA fingerprints are maternally transmitted, and all maternal relatives have the same mito type. The commonality of the type depends on the frequency found in a database and brings in statistical arguments. Fortunately, mito type is much less than 1% of DNA cases. *Id.*

and relevancy of toxicology or DNA testing will vary depending upon the particular facts of a case. The same is true for psychiatry.

Thus, when presented with psychiatric evidence, the trial court must determine not only whether psychiatry in general is reliable and relevant, but also whether psychiatry is reliable and relevant regarding the specific issue it is addressing in the case. Such a focus would require that, in addition to expert testimony on the diagnosis and evaluation of the defendant, the psychiatrist would also explain the significance and relevance of the following: psychological tests performed and the error rate of such tests; what controls exist to prevent against "cheating" or exaggeration of symptoms by the patient; the current state of scientific research into the diagnosis; and the reliability of the diagnosis and violence prediction. Because the expert is already subject to an inquiry (*voir dire*) of his qualifications, this inquiry into the reliability of the science itself can occur either simultaneously or by other experts prior to the admission of the expert conclusions.

In capital murder cases, the Supreme Court seems to have "assumed that experts are better than lay jurors at predicting violence. If they are not, then this testimony has no probative value and should be excluded on that basis alone."²⁴³ Since the majority of capital murder defendants do not suffer from a serious mental illness, they do not fit the profile of an individual about whom psychiatry can accurately predict future behavior. Additionally, since long-term predictions of violence are unreliable such testimony should be inadmissible.

In civil commitment cases, the question of future dangerousness is a fairly narrow one. The court wants to know whether the respondent is going to become violent in the very near future as a result of the respondent's current symptoms of psychosis or other exacerbation of the respondent's mental illness. The court is not deciding whether all individuals with that specific mental illness are violent, or whether the respondent will ever become violent at any point in the future. Rather, the court is focusing on one individual's behavior in the immediate future.

IV. CONCLUSION

In capital murder cases, scientific evidence should be allowed in court only if it passes scientific standards of reliability. Likewise, in civil commitment cases, the proponent of any psychiatric evidence should be required to introduce evidence of reliability linked to the actual diagnosis of the patient. The standard of admissibility should be the same in both cases but the result will likely be that psychiatric evidence is much more curtailed in capital murder cases, but will carry more weight in civil commitment hearings.

243. FAIGMAN ET AL., *supra* note 14, at 84.

A reconsideration of the two cases described at the beginning of this article demonstrates the wisdom of reversing the current trend. In the case of Mr. Head, the young man who killed his mother while psychotic, the medical profession could have acted quickly to detain him once he began acting delusional. The detainment would have confined him during the most acute time period of his illness and possibly prevented him from killing his mother.

Once detained, the court would review not only Mr. Head's current mental state, but also the following significant factors: (1) his documented history of serious mental illness,²⁴⁴ (2) his marijuana use,²⁴⁵ (3) his non-compliance with medications,²⁴⁶ (4) his recent, extremely violent suicide attempt,²⁴⁷ and (5) his documented hallucinations that included homicidal and suicidal thoughts.²⁴⁸ Such evidence greatly enhances the reliability of the psychiatrist's prediction, and the testimony of the psychiatrist as an expert is necessary to explain the diagnosis and treatment of schizophrenia. All combined, such factors demonstrate that he presented the clinical picture of an imminently violent schizophrenic, and the court would have civilly committed him for involuntary psychiatric treatment. His mother's desperate pleas would not have been ignored and left to foreshadow her fate. Mr. Head should not have had to kill someone to get help.²⁴⁹

In the capital murder trial of the wrongly convicted Mr. Adams, however, the psychiatrists' testimony would be inadmissible for a variety of reasons. First, psychiatry does not condone diagnosing a patient without first examining him or thoroughly reviewing the relevant medical records.

244. "Before his mother's death, Head had been treated and hospitalized repeatedly at various mental health centers around Fairfax. That included a five-week stay at Inova Fairfax in May and June 1998 after slashing his own throat through to the trachea and leaping out a second-floor window of his house." Tom Jackman, *Reston Family Sues in Insanity Case*, WASH. POST, Oct. 1, 2000, at C1.

245. "[I]t is my opinion to a reasonable degree of professional certainty that the following diagnoses apply in Mr. Head's case: Axis I: Schizoaffective Disorder, Mixed Type Cannabis Abuse, in remission in a controlled environment." Psychological Report, *supra* note 1, at 44.

246. *Id.* at 5-17.

247. "Less than two months earlier, he'd been in the same unit after slashing his throat to the windpipe and leaping headfirst off a balcony." Jackman, *supra* note 4, at B2.

248. "Head told a social worker that night: 'I could lose control at any time. I could end it right here.' His medical chart included the notation, 'Homicidal and agitated (towards parents).'" *Id.*

249. Tom Jackman, *Reston Man Committed in Slaying of Mother; Mental Disorders Cited by Experts*, WASH. POST, Dec. 18, 1999, at B3.

A Reston man who beat his mother to death with a baseball bat last year—later telling doctors a chess piece had ordered him to kill her—was formally committed to a mental hospital yesterday. Alfred L. Head, 22, will be reevaluated regularly by a Fairfax County judge to determine whether he is fit to return to society . . . His attorney, Joanmarie I. Davoli, said the case 'underscores the flaw' in civil commitment laws because she said, Head's mother had tried to obtain help for her son but couldn't until he demonstrated that he was a danger to himself or others. By the time he did that, Zona Head was dead.

Id.

It is not a sound psychiatric practice to diagnose by answering hypothetical questions. Second, psychiatric evidence should not be admissible unless it is supported by credible evidence that there is scientific reliability in predictions of dangerousness. Third, the testimony of a psychiatrist is completely irrelevant unless the defendant actually suffers from a mental illness that produces delusions or hallucinations and thus interferes with his free will. Since none of these conditions were satisfied at the time of Mr. Adams' trial, the psychiatric testimony would have been inadmissible and the jury would have had to rely upon common sense to determine whether Mr. Adams should receive the death penalty.

Absent Dr. Grigson's testimony, the remaining evidence of prior criminality against Mr. Adams would have been "a drunk-driving conviction and a minor A.W.O.L. violation, the sole blemish on his record during three years of service as an army paratrooper."²⁵⁰ Without the testimony of the prosecution's psychiatrist, the jury would not have heard any prediction that Mr. Adams would continue killing if not executed. Perhaps the jury's decision would have been the same, but as Justice Blackmun stated in his dissent in *Barefoot v. Estelle*:

[It is unacceptable that] psychiatric testimony about a defendant's future dangerousness is admissible, despite the fact that such testimony is wrong two times out of three One may accept this in a routine lawsuit for money damages, but when a person's life is at stake—no matter how heinous his offense—a requirement of greater reliability should prevail. In a capital case, the specious testimony of a psychiatrist, colored in the eyes of an impressionable jury by the inevitable untouchability of a medical specialist's words, equates with death itself.²⁵¹

250. RADELET ET AL., *supra* note 8, at 62.

251. 463 U.S. 880, 916 (1983) (Blackmun, J., dissenting).